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THE
AMERICAN
MEDICAL DIGEST.

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*BIBLIOGRAPHY OF CURRENT MEDICAL LITERATURE,
ABSTRACTS AND REVIEWS,—IN THREE PARTS,
MEDICINE, SURGERY, DISEASES OF
WOMEN AND CHILDREN
AND OBSTETRICS.*

EDITED BY

JOHN C. LESTER, A.M., M.D.

CONTRIBUTORS.

ALEXANDER J. C. SKENE, M. D.,

Professor of the Medical and Surgical Diseases of Women
and Diseases of Children, Long Island
College Hospital.

ARTHUR MATHEWSON, M. D.

Professor of Ophthalmology, Long Island College Hos-
pital; Surgeon to Brooklyn Eye and Ear Hospital.

JOHN C. SHAW, M. D.,

Superintendent of Kings County Lunatic Asylum.

F. R. STURGIS, M. D.,

Professor Venereal Diseases, University of New York;
President N. Y. County Medical Society;
Visiting Surgeon to Charity Hospital.

GEORGE HENRY FOX, M. D.,

Clinical Professor of Diseases of the Skin, College
Physicians and Surgeons, New York.

CHARLES JEWETT, M. D.,

Professor Obstetrics, Long Island College Hospital;
President Kings County Medical Society.

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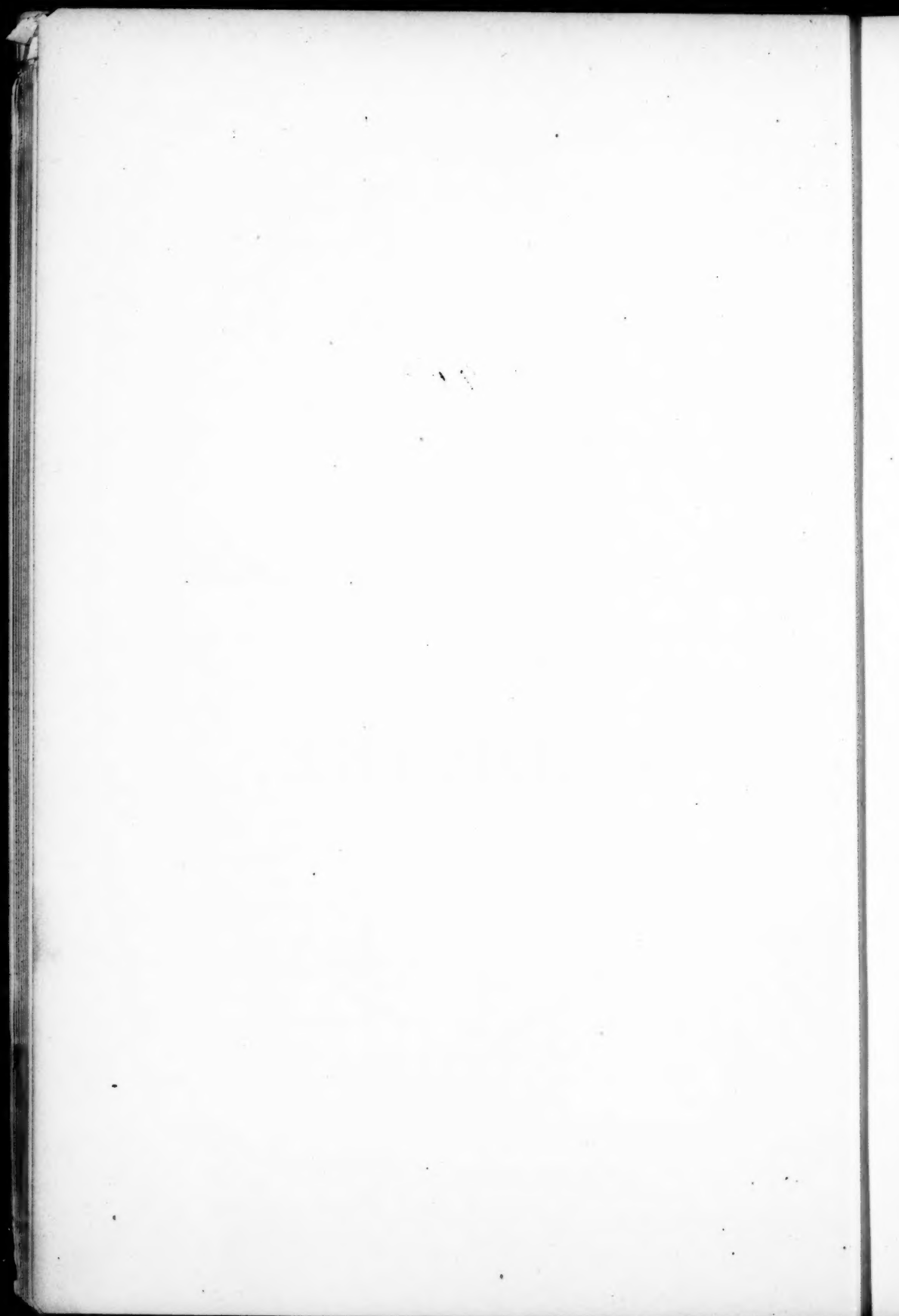
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THE AMERICAN MEDICAL DIGEST.

PART. I.

MEDICINE.



THE
AMERICAN MEDICAL DIGEST.
15968
VOLUME I.

M E D I C I N E .

CONSTITUTIONAL DISEASES.

The Treatment of Typhoid Fever.

Dr. F. A. McEWEN, of Aberdeen, describes the plan which he pursued in an epidemic of typhoid fever, with very satisfactory results. It was as follows :

In the great majority of the cases looseness of the bowels, with the characteristic evacuations, was present ; but unless the diarrhœa continued distressing I generally allowed it to go on. When along with the looseness of the bowels there was restlessness and want of sleep, I found small, repeated doses of Dover's powder most beneficial in subduing the diarrhœa and inducing quiet repose. In a few of the cases, instead of looseness there was constipation with tympanitic distension. The constipation I never tried to obviate, and the bowels always acted in good time. One case in particular, where the patient remained ten days without having her bowels moved, made a very good recovery. During the whole time there was tympanitic distension, and a continual discharge of flatus ; but at the end of the

ten days the bowels were moved naturally. I confined my patients almost exclusively to milk, with a little lime-water or soda-water added. When the frequency of the pulse denoted great weakness of the circulation I gave from half an ounce to an ounce of good old Scotch whisky, three or four times a day ; and the administration of this stimulant I invariably found to have a strengthening effect upon the action of the heart. Sponging the body once or twice a day with tepid water was agreeable and refreshing to the patients, and was generally followed by a sense of comfort.—

Med. and Surg. Reporter.

Therapeutic Observations in Typhus Abdominalis.

(*Jarhrbch. f. Kindhlkd.*, XVII. B., 1 H.).

PROF. J. KAULICH.

The course of treatment is as follows: At the beginning of the rapid rise of temperature in the afternoon or evening, the child is wrapped in wet sheets and lightly rubbed, and this repeated at short intervals until there is a perceptible decrease of temperature. Generally

four or five wrappings are necessary. Then a large dose of quinine is given (0.5 grm. to 2.0 grm.). In the most favorable cases the temperature on the next morning is normal, or subnormal. This is the effect desired, and when once attained it will usually be found that the wet packings alone will reproduce it on successive days. So soon as this normal temperature is attained the increased nourishment must begin, and after a day or two further increase will be possible, and so on, from day to day, until sometimes even during the fever, full diet may be given.

It was found that the earlier in the case this treatment was begun the better was the result. It seemed also to work better the younger the children. In older children cold baths were used instead of the packings. The quinine was given in wafers so as not to upset the stomach. The author gives thirteen cases, with temperature curves, which seem to justify his positions. He admits that in the normal course of a typhoid fever there is, towards the second half of the case, a remission of the fever and bettering of the symptoms, even without treatment; but his point is that by energetic antipyretical measures we may move this point forward to the very commencement of an attack. He makes two definite conclusions:

1. In most cases of typhoid, especially in young children, the temperature may be so controlled by antipyretic measures that the typhoid manifestations disappear.

2. Early nourishment not only does no harm, but re-supplies the loss of weight from the fever either in part or wholly during the febrile stage, thus reducing to the minimum the stage of convalescence.—*American Journal Obst.*

Malaria Treated with Pilocarpin.

GASPER GRISWOLD, M. D. (*New York Medical Journal*), says the salts of quinia are considered specific in malarial affections, and their efficacy is beyond question, but in many cases they do not act promptly enough. An agent is needed that will antagonize the essential conditions of a chill at once; which given during a chill, will cut short, and which, given just as a chill is threatening, will prevent its occurrence.

At the time when each paroxysm was due, and two or three minutes after the chill had fairly begun, gr. 1-5th of the muriate of pilocarpin was administered hypodermically, patient's temperature taken every thirty minutes, after the pilocarpin was administered; and the paroxysm aborted, terminating in the sweat caused by the medicine—no hot stage occurring. The remaining case, the patient was a very large man, and the dose did not produce marked diaphoresis; the chill was not interrupted, its severity was diminished, and the pains in the back and loins disappeared. A hot stage occurred, shorter and less intense. A larger dose might have acted as in the other cases. In all the cases recovery followed the administration of a single dose of pilocarpin; in no instance did another chill occur. From these cases it seems fair to conclude (1) that pilocarpin, administered hypodermically, will promptly cut short the chill of malarial intermittent fever. (2) That in a large proportion of cases so treated the paroxysm aborts, terminating in the sweat, caused by the pilocarpin, no hot stage occurring. (3) That such abortion of a paroxysm is in itself sufficient to effect a cure in many cases. (4) That such an abortion is a valuable adjuvant to treatment with quinia during the intervals. (5) That

a dose of pilocarpin sufficient to produce this effect acts gently, without causing exhausting diaphoresis or unpleasant ptialism. (6) That the promptness with which an adequate dose of pilocarpin interrupts a chill is suggestive of its possible efficacy in cases of pernicious intermittent fever, where prevention of the full development of a paroxysm is often of first and all importance.

A Remedy for Intermittent Fevers.

DR. BRUNETI recommends, as an efficacious remedy in intermittent fevers, a preparation composed of twelve grammes (3 iij.) of the chloride of sodium and one gramme (15 grains) of ferric carbonate. This is to be divided into six doses, to be taken in twenty-four hours. To prevent the recurrence of the malady one dose a day is to be taken for the following week.—*Mich. Med. News.*

Headache from Malarial Poisoning.

R. Quiniae disulph., gr. x-xv.; acid. sulph. dil., ℥x. syrupi, 3 ij.; aquæ, ad 3 jss. M. Sig. To be taken two or three hours before the expected paroxysm and afterwards a third part three times a day till cinchonism is produced.

Should the headache recur from time to time give the following:

R. Liquor Fowleri; tinct. belladonnæ, āā 3 j.; aquæ puræ, ad 3 jss. M. Sig. A teaspoonful in a wineglassful of water three times a day.—*Hosp. Gazette.*

Intermittent Fever.

For a cheap prescription the following is very efficient:—R. Quiniae sulphat., gr. xl.; cinchoniae sulphat., 3 ij.; chloroform, f. 3 j.; tinct. cardamomi comp., f. 3 j.; misturæ acaciæ, f. 3 ij.; aquam, ad., 3 vj. M.—Take a dessertspoonful three times a day. More frequently

quinia (about 12 grs. daily) is relied upon, in simple solution with dilute sulphuric acid and water (disulphate).—*Ibid.*

Chronic Malaria.

R. Quiniae sulphat., gr. ij.; ext. nucis vomicæ, gr. ½; acid. arseniosi, gr. ¼; Fiat pil. s. t. d. M.—If there be much enlargement of the spleen, ergot by the mouth or hypodermically is used.—*Ibid.*

Intermittent Facial Neuralgia and Cephalalgia.

R. Dextro quiniae, grs. xxx.; ammonii chloridi, grs. xx. M. Ft. chart, No. vi. Sig.—One powder three times a day.—*St. Louis Med. & Surg. Jour.*

Aconite in Remittent Fevers.

DR. GERALD BOMFORD writes to the *Practitioner* (London): The good effects of aconite in this class of fevers may be summed up as follows:

1. It reduces the temperature.
2. It reduces the rapidity of the pulse, and makes it full and strong.
3. It cleans the tongue and restores the digestive functions.
4. It induces sleep.
5. It increases the quantity of urine, and seems to have a direct effect in removing the symptomatic congestion of the kidneys.
6. It promotes perspiration. I may add that it is exceedingly grateful to the palate of a fever patient.—*Am. Practitioner.*

The Use of Ammonia in Pulmonary Diseases.

At the meeting of the Royal Belgian Academy of Medicine, April 30, 1881, M. MELSSENS presented a memoir on the therapeutic applications of ammonia. He concluded, from the fact that phthis-

cal patients are benefited by inhaling the vapors of carbonate of ammonia emanating from stables, that the continuous and moderate inhalation of that salt would be efficacious in other pulmonary affections. He accordingly made the experiment upon himself during an attack of bronchitis, by wearing, in a bag attached to his shirt, several pieces of ammoniac carbonate. Having been completely cured in a few days by this treatment, he subsequently employed it in his practice, with uniform good results. He also applies the remedy directly to the respiratory passages by means of the spray, with equal success.—*Bulletin de l'Académie Royale de Médecine de Belgique*, vol. xv., No. 4.

Lactic Acid in Phthisis.

A. D. MACDONALD, M.B., C.M., writes to the *British Medical Journal*:

I have been struck by the observation that in some cases where there was a strong hereditary predisposition to phthisis acute rheumatism had supervened early in life, and by middle age phthisis had not yet appeared. Besides, I understand that in Madras, for example, there is a large proportion of rheumatism to a comparatively smaller proportion of phthisis. May there not then exist some degree of antagonism between these diseases, and is there not in the latter a deficiency of the lactic acid poison of the former?

On the 5th of June last I administered ten minims of lactic acid thrice a day to a patient who had a vomica in the apex of the right lung, and the left apex had a deposit of tubercle. On the 11th the patient expressed herself as feeling better, but she complained of rheumatic pains in her joints for about two hours after each dose, and this in the absence of being informed as to any effect to be produced. Another patient to whom

I gave the acid stated that it relieved her cough more than anything else she had taken. Both thought the acid very agreeable as a thirst-quencher.—*Med. Record*.

The Pathology and Treatment of the Diarrhoea of Phthisis.

Dr. C. T. WILLIAMS has a series of articles upon this subject in the *Lancet*. He divides the different diarrhoeas of phthisis into three classes. The first includes those simply due to irritation or a catarrh of the intestines. The treatment consists simply in altering the dietary and ordering a few doses of alterative and purgative medicine, with some alkali to reduce the acidity. The second form is that arising from ulceration. The ulcers usually begin in the small intestine, near the ileo-cæcal valve; as the ulceration progresses, however, the large intestine becomes most affected. The treatment of this form requires very careful attention. It resolves itself into three sets of measures: (a) Rest in bed with the administration of easily assimilable food, such as chicken-broth, beef and veal tea, milk-gruel, blanc-mange, always combined with *liquor pancreaticus*, after the methods described by Dr. Wm. Roberts. Koumis is also highly recommended. (b) Warm applications to the abdomen, in the form of linseed poultices, turpentine stupes, or hot-water fomentations, to reduce the pain and produce derivation to the skin. In severe pain small blisters are useful. (c) Internal medicines: bismuth and opium will answer in slight cases. The most powerful astringent is sulphate of copper in one-quarter or one-half grain doses. Of vegetable astringents, tannic acid is the best, in four-grain doses. Indian ball is often efficacious. If the ulcerations are largely in the colon, injections or supposi-

tories are often needed. The ordinary enemata of lead and opium will sometimes answer, but in severe cases a pint or a pint and a half of linseed tea, combined with medicines, are needed. Linseed tea seems to be especially efficacious. The third form of diarrhoea is due to waxy degeneration of the intestinal wall. This is hard to deal with successfully. The waxy degeneration indicates a need for phosphates of potash. The diarrhoea can only be treated, as in other diarrhoeas, by the use of astringents.—*Can. Lancet*.

Pepsin as a Solvent for Diphtheritic Membrane.

A case is related by Dr. W. HALE WHITE (*Lancet*), in which acid glycerin of pepsin was sprayed into the throat. The result was quite satisfactory, the pepsin seeming to soften and gelatinize the diphtheritic masses.—*Med. Record*, vol. xx., No. 22.

Treatment of Subacute and Chronic Gout.

Dr. HADDEN reports the following (*Med. Record*):

Case I.—T. M—, aged thirty-five, stonecutter, married, native of Ireland; suffered from subacute gout; on October 6th came under my care, suffering considerable pain; hands and feet swollen, red, and some pain and swelling in the other joints; evidences of the urates of soda deposits in many of the joints. Temperature a little above normal. Urine alkaline, sp. gr. 1010. On microscopic examination, deposits of the urate of soda were found. Bowels were constipated.

Treatment ordered: To relieve the constipation, a four-grain pill of comp. colocynth at night. Weak alkaline washes were applied to the painful members. Was given five grains salicylate of soda three times daily after eating,

and opiates in sufficient quantities to secure rest. Was put upon animal diet, with the exception of such vegetables as possess neither amylaceous nor saccharine principles. On the 20th the acute pain had nearly subsided; has much better motion in feet and hands; can walk without much difficulty; is comfortable nights without opiates; is not troubled with flatulence. On 26th was discharged, feeling quite well.

Case II.—G. A—, aged forty-eight, butcher, married, native of England; admitted November 16, 1880, suffering from subacute gout. Has had previous attacks; wrists, elbows, and shoulders of the right side, both knees and ankles, and hands were affected, and had gouty deposits in the smaller joints, and other evidences in the urine and alimentary canal of gout were present. Was placed upon the treatment on 17th, as above mentioned. Urates disappeared from the urine in a few days, and became otherwise quite normal. Patient went on without interruption through convalescence. December 9th, discharged, feeling well.

Headache Associated with Gouty Diathesis.

R. Liq. potass. ars., liq. potassæ, āā ʒ j.; tinct. colchici, ʒ ij.; tinct. lavandulæ. co., ʒ iij.; aquæ puræ, ʒ vj. M.—Sig. A tablespoonful in a wineglassful of water twice a day after food.

Pleurisy.

Chronic pleuritic effusion may be removed by half-drachm doses of fluid ex. of jaborandi, given two or three times daily, just sufficient to keep up free action of the skin and kidneys.—*Med. Gazette*.

Diphtheria.

Dr. J. R. JONES says, in *Detroit Lancet*: Of the various remedies now used and advised which I have tried, Monsel's

solution of the subsulphate of iron has proved the most efficient for checking the spreading of the false membrane and causing its removal. Brushed on thoroughly with a camel's hair pencil, it does not burn nor irritate, but causes a disagreeable puckering of the throat, and although the patients do not like it, they readily submit to its application from the relief it affords.—*South. Med. Rec.*, Vol. XI., No. 8.

Tr. Iodine in Diphtheria.

Dr. SATHIER relates in the *Chicago Med. Review* his successful treatment of cases of diphtheria by the use of ten to twelve drop doses of tincture of iodine well diluted, every hour. This was continued as long as the fever persisted. After this the remedy was given at increasing intervals until it reached three hours. He made local applications at least twice a day.

Diphtheria.—Salicylic Acid.

Dr. WEISE recommends very highly a two per cent. solution of salicylic acid in diphtheria. This is a strongly antiseptic solution, but not a dangerous one. He employs the following formula:—

R. Acid salicyl., i.og; sp.vini rectif., glycerine, āā 25.00.

At the same time he uses benzoate of soda internally.

Tartaric Acid in Diphtheria.

A writer in a French journal advises tartaric acid as a local application in diphtheria. He says: "The tartaric acid, acting on the false membrane, changes it into a gelatinous mass, and thus favors its expulsion." The formula he uses is:—

R. Acid tartaric, 3 iiiss.; glycerine, 3 ivss.; aquæ menthæ pip destil., 3 ss.

Applications of this should be made every three hours, followed soon after by the use of lemon juice.—*South. Med. Record*.

Chloroform in Diphtheria.

Dr. LATHROP, of New Hampshire, at American Medical Association, said that he had experimented with chloroform largely, and finds it a highly useful agent. He uses it in diphtheria and other throat affections, applied on a piece of cotton attached to a tube or pen-holder. The patients usually required visiting no longer than four days; but the cases were not so malignant as had been reported in other localities.

No unpleasant effects have ever followed this plan of treatment, and the child, in true diphtheria, does not complain of *smarting* from the application of chloroform. He had used this plan of treatment in one hundred cases. Of course constitutional measures are added.

Dr. MCNEAL, of Gettysburg, Pa., recommends the following: Potass. bromid., 3 j.; potass. chlorat., 3 ij.; acid carbolic., gr. xx; aquæ, Oj. Use in an inhaler. Locally, chloroformi, 3 ij.; lin. saponis, 3 j.—3 ij.

Dr. F. E. HITCHCOCK, of Rockland, Maine, uses equal parts of sulphurous acid and water in an atomizer. The proportions can be varied, and the acid used as a gargle, with cold effusion externally.—*Atlanta Medical Journal*.

Pilocarpine in Diphtheria.

Dr. GUTTMAN recommends the following:

R. Pilocarpine mur., gr. $\frac{1}{2}$ – $\frac{3}{4}$; pep-sine, gr. 1–1 $\frac{1}{2}$; acid. hydrochlor., gr. iij.; aq. distill., 3 ijss; M. Sig., 3 j.; hourly for children.

Treatment of Acute Articular Rheumatism.

Dr. CARPINI (*Annali Universali di Med. e Chir.*, 1881, Nos. 1 and 2) has reached the following conclusions:

1. Salicylate of soda is indicated in cases of acute polarthritic rheumatism, when the joint symptoms are very well marked.
2. Quinine is the best remedy and the most prompt in its effects, when it is presumed to be of malarial origin, or when it is complicated by malaria.

3. Benzoic acid or benzoate of soda is suitable for such cases as are complicated by nephritis.

4. Blisters are the surest treatment if the rheumatism is confined to one joint, or if the affected articulations are few in number.

Contraindications to the use of salicylate of soda: 1. Grave affections of the heart. 2. Persistent gastric disturbances. 3. Renal complications; not that the salicylate produces nephritis, but it aggravates renal affections. Salicylate of soda should be given only with the greatest precautions to infants, to the aged, or to those enfeebled by long sickness.—*Lyon Medical.*

Acute Rheumatism.

In acute rheumatism the salicylate of sodium is used in ten grain doses, giving usually about a dram daily.

R. Sodii salicylatis, gr.x.; glycerinæ, ℥x.; spt. lavandulæ comp., ℥xx.; liq. ammoniæ acetat., q.s.ad f ʒ ss. M.

The joints affected are wrapped loosely in cotton wadding; if very painful laudanum and water compresses may be used. A restricted diet is enjoined, and saline purgatives if the bowels should be constipated.—*Med. Gazette.*

The Treatment of Rheumatism by Collodion.

Dr. E. E. RIOPEL (*Med. and Surg. Reporter.*) says: Some years ago we

applied collodion to a rheumatic joint, which gave relief; but it was not applied with the object of giving relief *per se*, but only as a better substitute for the bandage, which annoyed the patient much, from a hyperæsthetic condition of the part. And so this application had disappeared from memory until, exhausted with a couple of cases that medicine would give no relief to in the least, we again tried the collodion on the wrist and knee of a dropsical lady sufferer. It gave relief but formed considerable tumefaction in the hand and foot; to these a close-fitting bandage was applied and all trouble ceased, and after continuing this for two weeks it was removed without any further trouble. The second, Mrs. M., a lady of fine physique and good health, had rheumatism of the ankles, especially of the left and knee. In the second week of the affection collodion was applied, and kept on for four weeks, all the while giving entire relief. When it was cleared away all traces of the affection had disappeared. The caoutchouc collodion was used, on account of its elastic and contractile properties.

Treatment of Small-pox by Ether and Opium.

M. DU CASTEL in his service in the Hôpital St. Antoine observed seventy-six grave cases; thirty-six among these, having confluent small-pox, were treated in this way. In almost all the cases suppuration did not take place, and desiccation occurred from the sixth to the ninth day. The following observations may be taken as typical: A girl of twenty-two entered the service on the day of the eruption, with grave general condition, extreme agitation, skin scarlatini-form in color and covered with small papules placed very near each other. Temperature 40° (Centigrade).

The next day the contents of a hypodermic syringe of ether was injected; fifteen centigrams of thebaic extract and fifteen drops of sol. ferri perchlorid., in 125 grams of water, were administered.

On the 26th inst. (three days later) a few scattered vesicles were formed; desiccation took place without suppuration, and was complete two days later.

The risk of abscess following the ether injection is avoided by inserting the needle deep into the tissues.

This treatment appears much more efficacious in vaccinated persons.

The best method of applying the treatment is to inject the contents of a hypodermic syringe of ether morning and evening, giving fifteen to twenty centigrams of extract thebaic and fifteen drops of sol. ferri perchlorid., much diluted, in the course of the day.—*Med. and Surg. Reporter*, vol. 45, No. 16.

Abortive Treatment of Small-Pox by Salicylic Acid.

Dr. EDWIN ROSENTHAL has employed salicylic acid in many cases of small-pox with good results. The formula employed by him is as follows:

℞. Acidi salicylici, 1 drachm; spts. vini rectificati, $\frac{1}{2}$ ounce.

Mix and add:

Elix. simplici, q. s., ad 6 ounces.

For the angina of variola, he uses in conjunction therewith, the following gargle of xylol, and finds it very satisfactory:

℞. Xylol., 1 drachm; gum acaciæ, 2 drachms; aq. menth. pip., 6 ounces.—*Misce, fiat emulcio.*

Use as a gargle and mouth wash. He confirms the statement that salicylic acid in small-pox reduces the temperature, is sedative, and modifies the eruption.—*Medical Bulletin.*

Chloral in the Treatment of Cerebro-Spinal Meningitis.

Dr. GEO. GOODHUE, of Dayton, Ohio, gives the history of a severe case which terminated in recovery, under the free use of chloral. The temperature on the first day was 106°. Twenty grains of chloral were administered every half hour, until three drachms had been taken, which reduced the temperature to 102°. The amount of chloral given during the twelve days he was ill amounted to 1015 grains.

Milk constituted his entire diet, from time of attack till convalescence was fully established. The quantity which he took daily was not measured by drachms but by pints, and not once did his stomach refuse to perform the work imposed upon it; showing that chloral, even in such large doses, and frequently repeated for twelve days, did not interfere with or impair in the least the functions of this important organ.

The therapeutical action of chloral in this disease the author sums up as follows:—

1. It relieves the severe pain, either mechanically, by removing congestion, or as a true anesthetic, or, more probably, by a combined action in both directions.
2. As a sequence of the relief of pain muscular quietude is produced.
3. By its hypnotic influence, abundant and refreshing sleep is obtained.
4. By its antipyretic influence, temperature is reduced.
5. It produces no constipation, but probably has a slight laxative effect.
6. It does not disorder the stomach or materially alter any of the secretions.
7. It produces no appreciable effect on heart or respiration.
8. It is not cumulative in the system.—*Med. and Surg. Reporter.*

DISEASES OF THE NERVOUS SYSTEM.

Importance of the Early Recognition of Epilepsy.

E. C. SEGUIN.

After describing a number of cases of epilepsy that had been incorrectly diagnosed, the author concludes that the misapprehensions were due to two causes: (1) A physiological misconception in admitting the proneness to eclampsia in children older than three or four years. He holds that in the first two years there is great convulsibility, and that eclampsia is apt to ensue from many causes. Later, however, that tendency disappears. He acknowledges some few exceptions to this general rule however. (2) An etiological misconception in overestimating the exciting powers of local, internal and peripheral causes. He suggests, as a law, that after the third year of life, local irritations do not cause convulsions except in one morbidly predisposed. Convulsions may be caused by uræmia, which may occur at any period of life. The same is true of syphilis. Seguin lays it down as a law that in every case of eclampsia occurring after the third year, unless some sufficient cause other than epilepsy be found, the bromides should be administered for many months. Petit-mal, or epileptic vertigo, according to Seguin, is even more intractable than grand-mal. It may be differentiated from ordinary vertigo.

(1) By subjective symptoms. In vertigo the patient has a feeling as if he were whirling, or as if the objects about him were turning. In petit-mal there is no such sensation, merely a feeling of confusion, or of something rising to the throat or head. The onset is likewise quite sudden.

(2) By objective symptoms. In faints and in some hysterical states the patient is limp. In petit-mal the patient is rigid, with staring eyes and dilated pupils.—*Pacific Med. and Surg. Journal.*

Cod-Liver Oil in Epilepsy.

Dr. FAIRBAIRN, of Brooklyn, N. Y., writes: A young lady suffering from epilepsy has been under my care for the past five months, who has taken bromide of potassium in large doses for nearly a year, and by this remedy cod-liver oil has warded off the above troublesome results. The mode of taking it was this: Brom. potas., 3 ss., was taken thrice daily after eating; this was followed one hour after each dose by ol. morrhue, 3 ss. When first attacked by the malady she had eight convulsions in twenty-four hours. She began the bromide in 3 ss. doses, but was compelled to stop it on account of the gastric derangement. A friend recommended the cod-liver oil. She resumed the bromide adding the oil, and has taken it without further trouble since. The eruption, before profuse, disappeared under this management. The disease has been well controlled, only four convulsions having occurred in the past seven months. I doubt not that the cod-liver oil has had its share in the direct benefit done to the nervous system, besides affording a protection from the irritating salt to the coats of the stomach. In summing up the good effects of the oil I find: 1st. Absence of the digestive disorders; 2d. Absence of the acne eruption; 3d. That the anæmia usually found in persons taking this medicine continually, is far from being marked; 4th. The body is better nourished, and appetite unimpaired. I have made trial of this treatment in other cases, with similar good results.—*N. Y. Med. Record.*

Treatment of Epilepsy.

Dr. JAMES M. DAVIS (*Therapeutic Gazette*). I first remove all cause as far as possible, and put my patients in the best condition I can by appropriate treatment. I then put them on the following: *R.* Potassii bromidi, gr. xx.; ammonii bromidi, gr. x.

Mix. Sig.—For one dose, three times a day. At the same time I give 1-100 of a grain of sulphate of atropia three times a day, and continue this treatment for six or eight months, after which stop and give: *R.* Zinci valerianatis, 3j; ext. belladonnæ, gr. x.; acidi arseniosi, gr. iij.; ext. gentianæ, q. s.; pills No. xxx.

The first week give two pills a day, the second week three pills a day, and the third week four pills a day, until all are taken. When I refill this prescription, I double the amount of zinc, and after about one month on this course, I go back to the bromides again for six or eight months, and then change again to the pills, alternating in this way, and continuing the treatment for two or three years. If the patient becomes anæmic from continued use of the bromides, give iron in any convenient form; I prefer dialyzed iron.

Hydrobromate of Iron in Chorea.

A correspondent of the *Lancet* gives the following case:

A patient, an anæmic, badly nourished girl, aged fourteen, was frightened by a dog, and almost immediately afterward developed, choreiform movements. At the time of my visit, two days after the onset, the child's contortions were painful to witness; her sleep was disturbed, and it was with difficulty she could convey her food to her mouth. The heart sounds were normal, and there was no history of previous cardiac or rheumatic

affections. After attending to her digestive organs, I prescribed syrup of hydrobromate of iron in twenty minim doses. The effect was very marked. The sedative action was speedily apparent, as the convulsive movements became gradually less severe, and the control of the muscles more readily recovered; whilst at the same time the anæmia was yielding to the accompanying iron. The continued use of the drug for about twenty days completely removed the affection.—*Med and Surg. Reporter.*

Varatrum Viride in the Treatment of Chorea.

The following case of acute chorea, successfully treated with large doses of veratrum viride, by Dr. F. E. GARY, of Abbeville, S. C.

F. B., while at college the past winter, suffered from a very severe attack of acute rheumatism, and while convalescing from this disease, and when it was supposed he was nearly well, irregular movements of the muscles, so characteristic of chorea, were noticed. At first, these movements were confined to the left side, but as the disease advanced they became general. He was put upon the most approved treatment for chorea—such as iron tonics, oxide of zinc, chloral, arsenic, cimicifuga racemosa, etc. No benefit was derived from the administration of these remedies, and as the symptoms were becoming more aggravated, such as difficult deglutition, the drawing of the mouth to one side, the rolling of the eyes in various directions, flushed face, pain in the head, constant movement of the hands and feet, quick pulse, etc., threatening a fatal termination from congestion of the brain, it was determined to put him upon large doses of veratrum viride, ten drops every two hours, increasing two drops each dose until

nausea, or a considerable reduction of the pulse should be observed.

He made a good recovery.—*Med. and Surg. Reporter.*

Phosphide of Zinc in Locomotor Ataxia.

Two cases of ataxia are reported by Dr. Hastings Burroughs, of Paris, in which very great benefit was obtained by the use of phosphide of zinc. The drug was given in doses of one-tenth of a grain per day, increased to half a grain per day.—*Medical Press and Circular.*

The Frequency of Symptoms in Locomotor Ataxia.

Dr. BERNHARDT (Berlin) has tabulated fifty-eight selected cases of locomotor ataxia with a view of determining the frequency of important symptoms. From his statistics it appears that the absence of tendon reflex is the most constant sign of tabes. Thereupon follow in frequency, ataxia, feeling of lassitude, vertigo when the eyes are closed, loss of sensation, lancinating pains, and paresis of the bladder. Relative to the etiology of locomotor ataxia, Dr. B. expresses the view that over-exertion, sudden drenchings, and colds are of greater importance than syphilitic infection.—*Louisville Med. Journal.*

Neuralgic and Nervous Headache marked by General Debility and Defective Nutrition.

R. calcis hypophos., gr. 80; tinct. ferri perchlor., 3 iij.; quiniæ disulphat., gr. xvj.; strychniæ, gr. ss.; spt. chloroform, 3 ij.; syrupi, 3 jss.; aquæ puræ ad. 3 viij.—M. Sig. A tablespoonful three times a day in a wineglass of water.—*Hosp. Gazette.*

A Case of Facial Paralysis and Lumbago.

DR. C. H. WAGNER, WATERFORD, MISS.

(*Southern Med. Record.*)

Eight months ago I was suddenly attacked by paralysis of the muscles of the left side, which are supplied by the portio dura of the 7th pair—æsthesia remaining unimpaired. Besides the usual appearances and symptoms, such as inability to laugh, whistle, raise the eyebrows, shut the eyelids, to spit straight, the chop-fallen cheek, etc., there were others which produced serious misgivings in my mind as to the probable result of the attack, particularly as my father and one of my brothers died of paralysis: they were diplopia, considerable vertigo, a feeling of oppression and heat in the head, buzzing in the ears, and a creeping, gnawing sensation within the lower half of the occiput. The first thing I did was to take a strong drastic cathartic, after the operation of which I immediately commenced the use of the extract of ergot in somewhat larger doses than I should perhaps be willing to administer to others, to relieve the highly probable hyperæmia of the brain and to guard against its possible consequences. I then commenced the use of one-tenth grain of phosphide of zinc and one-twelfth grain arsenite of soda in solution, three times a day alternately. Under the steady use of these remedies, a gradual, progressive improvement took place, which terminated in perfect recovery after a comparatively short time. I will here incidentally mention that the use of tobacco produced a temporary stop in the improvement, so long and as often as it was used.

To my surprise I also got rid at the same time, of another complaint (and have not felt it since) from which I had been almost constantly suffering, more or less, for the last twenty years—lumbago.

Nitrite of Amyl and Nitro-glycerine for the Relief of Toothache.

Dr. F. P. ATKINSON recommends in the *Practitioner*, the application of either nitrite of amyl, or a one per cent. solution of nitro-glycerine, as an efficient remedy for toothache.—*Med. and Surg. Reporter*.

Chloral and Camphor.

Dr. D. B. SIMMONS, having seen a case of poisoning by a mixture of equal parts chloral hydrate, and camphor, thought of employing the same preparation in medicinal doses. Twenty drops of this mixture, given in a mucilaginous potion, calmed an attack of acute mania. He thinks this combination might be made use of in hydrophobia, tetanus and delirium tremens. Camphor and hydrate of chloral, thus associated, act with much greater energy than separately.—*St. Louis Clin. Record*.

The Treatment of Ptyalism in the Insane.

ERNEST DAUJAT states that the insane have a great toleration in respect to atropine, which has also been observed by others.

The author thus sums up his conclusions:

1. The neutral sulphate of atropine is, without doubt, very efficacious in the treatment of the ptyalism of the insane.
2. When it does not completely cure the salivation, it diminishes it considerably; and when it occurs it never attains its former intensity.
3. The cure of salivation generally requires a course of treatment lasting a mean length of three weeks, and the administration of neutral sulphate of atropine in daily doses of from 1 to 3 milligrammes, progressively increased.
4. The length of treatment seems to bear a proportion rather to the length

of time the affection has existed, than to its intensity.

5. Alienated persons seem to support well the sulphate of atropine.

6. It is well to note also the good effects that have been attained in cases complicated with bronchorrhœa and epilepsy. Finally, let us note the cure of a rebellious and very abundant epiphora.—*Lyon Medical*.

Ergot in Neuralgia.

Dr. MARINO, of Palermo, says that local injections of ergot give better results than any other treatment in tic douloureux, not even excepting quinine. Some cases, not all, of sciatica were relieved in the same way. Other forms of neuralgia should receive the same treatment. The injections usually cause pain, but abscesses seldom follow if cold water compresses are applied to the point of puncture. One or two injections suffice, as a rule, but they may have to be continued some time. About two grains of ergot, in water or glycerine, is the proper dose.—*London Med. Record*.

Epigastric Pressure in Obstinate Hiccough.

The *Journal des Sciences Medicales de Louvain* relates that M. Deghillage, of Mons, was called to a young lady suffering from very violent hiccough, with spasm of the glottis. The patient had been over an hour in this state, and was unable to articulate a syllable. There was no fever—no signs of heart trouble. The only cause that could be assigned was that the patient had the lower limb chilled a few days previously during her menstrual period. Inhalation of vinegar and Hoffman's anodyne and the application of sinapisms had been tried, without effect. Recalling Rostan's precept for such cases, M.

Deghilage applied the palm of the hand to the epigastrium and exercised strong pressure. There was slight amelioration, the movements were less convulsive, and the dyspnœa less intense. A large pad of linen was then applied over the epigastric region and pressed strongly inward by means of a bandage passed around the body. In a very short time complete relief was obtained. The pad was left several hours in position, and, when it was removed, the symptoms did not return.—*Med. & Surg. Reporter.*

Galvanization in Nervous and Mental Disorders.

The experience of Dr. E. C. Mann confirms the opinion of Bartholow that "galvanism is highly serviceable in certain vascular states of the inter-cranial organs," and that "the relaxed state of the vessels following acute meningitis or cerebro-spinal meningitis, may be toned up, and soft, unorganized exudations remaining after the acute inflammation absorbed under the stimulation of galvanism." By the constant current, applied twice daily, he has recently cured a young merchant of New York, who was in the incipient stage of insanity. The only other treatment was cathartics and quieting evening treatment. He says that the effect of galvanism to constrict the cerebral vessels may be easily demonstrated upon a kitten, from whom a portion of the cranial wall has been removed. In twelve seconds the anæmia begins to manifest itself. He agrees with Bartholow that the faradic current does not effect these changes, because it does not penetrate the cranial walls; therefore only galvanism is useful. It is indicated in neurasthenia, associated with hyperæmia, to relieve the blindness and deafness following cerebro-spinal meningitis, and in neuralgia of the solar plexus, the cardiac plexus, in gas-

trodynia, ovarian neuralgia, etc. It is thought that it may prove an important agent in ophthalmology to remove the opacity of the crystalline lens, dissolving incipient cataract. No doubt the therapeutic value of this agent is to receive more attention in the near future.—*Detroit Lancet.*

A Remedy for Hiccough.

Dr. M. S. LESLIE, of Lexington, Ky., says: that the best remedy in ordinary hiccoughs is about twenty-five grains of common table-salt, placed in the mouth and swallowed with a sip of water.—*Med. Record.*

Congestive Headache.

R. Ammon. bromid., 3 j.; spt. amm. aromat., 3 ss.; aquæ puræ, ad 3 jss. M.—Sig. To be taken on rising in the morning.—*Med. Gazette.*

DISEASES OF RESPIRATORY ORGANS.

Night-Sweats in Phthisis.

KÖHNBORN recommends the dusting of the body every evening with the powder used in the Russian army for sweating feet, viz.:—

R. Acidi salicyl., gr. xv.; amyli, gr. xxx.; talci, ad 3 j. M.

If the skin be very dry it may be rubbed with bacon, alcohol, or tannin, which will cause the powder to adhere to the body. The patient should hold a cloth to the mouth and nose during the dusting, that bronchial irritation from the salicylic acid may be prevented.—*Louis. Med. News.*

Treatment of Night-Sweats.

Several writers in the recent English journals unite in the opinion that probably the best remedy for profuse night-

sweating is *picrotoxine*, the alkaloid of *cocculus indicus*. The dose is one-sixtieth of a grain, and it should be made into small pills, one to be taken at bedtime and the other in the early morning.—*Med. & Surg. Reporter*.

Agaricus in Night-Sweats.

DR. WOLFENDEN speaks of this fungus as possessing properties which make it equally efficacious with atropia in night-sweats, while, at the same time, it is destitute of poisonous properties. He gives it in doses of from 10 to 30 grains of the powder each night. He bases his report on 40 cases of night-sweats, comprising tubercular and non-tubercular cases, in which the drug was uniformly successful. Its only drawback is the diarrhœa which it is liable to excite, but this tendency may be obviated by combining it with an astringent, or a few grains of Dover's powder. In view of the fact that coto has recently been recommended for night-sweats, we would suggest its combination with agaric when the latter disturbs the bowels. It would combine astringency with the more specific anti-diaphoretic properties claimed for it.—*Mich. Med. News*.

Phthisical Cough.

A linctus containing morphia or opium has a distinctly sedative action on the peripheral nerves. In laryngeal phthisis the cough is best treated by blowing through a glass tube, at the moment of inspiration, the following:

℞. Morphia sulphatis, gr. ½; amyli pulv., gr. ij.

Opium by the stomach is effective, but is apt to disturb digestion. A combination not so apt to do this is—

℞. Sol. morph. mur., acid hydrocyan. dilute, āā, ℥xviij.; spir. chloroformi,

acid nitric dilute, āā 3 j.; glycerinæ, 3 iij.; infus. cascarillæ, 3 ij. M.

A sixth part to be taken three or four times a day.—*Med. & Surg. Reporter*.

Inhalation of Eucalyptol in Pulmonary Affections.

DR. WILLIAM W. MOORE, of Warren, Mo., states in the St. Louis *Clinical Record*, that he has for many years suffered from a pulmonary affection, and such a tolerance has been established that large quantities of muco-purulent material collect in the bronchi during the night, which become dry by morning by the constant withdrawal of moisture by the respired air. Thus, it requires much time and effort to remove the tough, tenacious collection each morning. He used the eucalyptol by inhalation from a handkerchief. It seems to permeate the minutest bronchioles, and to soften the morbid secretions, so as to enable him to expectorate without difficulty. His condition has greatly improved under its use.—*Med. and Surg. Reporter*.

Peruvian Balsam in Laryngeal Ulcerations.

In this disease Dr. M. SCHMIDT recommends specially antiseptic inhalations of Peruvian balsam. Ten drops of a mixture consisting of two parts of Peruvian balsam to one of spirit of wine, are added to boiling water, and the vapor which rises is inhaled for some time; this is done three or four times a day.—*Med. and Surg. Reporter*.

Local Treatment of Cough.

PROF. ELSBERG recommends the local application of iodoform dissolved in sulphuric ether and flavored with wintergreen or musk, by means of a sponge and holder aided by laryngeal mirror.

Laryngeal Phthisis.

Dr. MAURICE SCHMIDT, of Frankfort-on-the-Main, claims, in this disease, to have had good results from a form of inhalation. He places a vessel containing a pint of boiling water over a spirit lamp, and pours in it ten drops of the following: *R.* Balsami peruviani, 3 iv.; alcoholis, 3 ij.; *M.* The patient inhales the vapor through a funnel of paper, folded in a conical form, about a yard in length. These inhalations should be repeated three or four times a day, and continued for months. (*Annales des Mal. de l'Oreille et du Larynx.* Mars., 1881).—*Med. and Surg. Reporter.*

A Stimulating Expectorant.

R. Am. carbonat., gr. v.; tinct. nuc. vom., ʒ x.; tinct. scillæ, 3 ss.; inf. serpenta, 3 j. Sig.—Three times daily.—*Fothergill.*

Asthma.

Apomorphia subcutaneously in $\frac{1}{10}$ grain doses, has been found effective.

R. Lobeliæ fol. pulv., stramonii fol. pulv., belladonnæ fol. pulv., aa 3 ij. 8.00 Gm.; potass nitrat. pulv., 3 iij., 12.00 Gm. *M.* Keep tightly corked.

The patient is required to shut himself in a small, warm, close room, and sprinkle the medicine on live coals, or smoke it in a fresh clay pipe, until relief is obtained, which is usually within ten or fifteen minutes.

Asthma.

Dr. R. M. LAWRENCE, who has studied the effect of ethyl iodide, recommends inhalations of fifteen to twenty drops of this ether from a handkerchief, repeated three or four times daily. It keeps the system constantly impregnated with iodine, and proves a most useful agent in spasmodic and other forms of nervous

dyspnœa, as also in the dyspnœa of chronic bronchitis. We may mention besides the good results obtained by its inhalation in hay-asthma. It seems to favor oxygenation of the blood and to stimulate the respiratory muscles.

R. Tinct. lobeliæ, 3 j., 30.00 fl. Gm.; ammon. iodidi., 3 ij., 8.00 Gm.; ammon. bromidi., 3 iij., 12.00 Gm.; syrup. toluatan, 3 iij., 90.00 fl. Gm.

M. S.—A teaspoonful every one, two, three, or four hours (Bartholow).

Of this prescription Dr. BARTHOLOW says: "It gives relief in a few minutes, and sometimes the relief is permanent.—*Prescriber's Memoranda.*

For Fresh Cold in the Head.

Dr. T. F. HOUSTON writes: For fresh cold in the head, accompanied with obstruction in the nasal passages:

R. Carbolic acid, 3 j.; absolute alcohol, 3 ij.; caustic solution of ammonia, 3 j.; distilled water, 3 iij.

M. Make a cone of writing paper; put a small piece of cotton in it; drop on the cotton ten drops of the mixture, and inhale until all is evaporated. Repeat this every two hours until relieved.—*So. Med. Record.*

Catarrhal Pneumonia.

Inhalations of carbolized spray, with the administration of ammonium chloride (gr. v.-xx.), potassium iodide (gr. iii.-v.), given in compound licorice mixture (3 ss.), or elixir of yerba santa, if there is much spasmodic cough, has given decided results. Night-sweats are controlled by ergot or atropia, and emulsion of cod-liver oil and extract of malt, if the nutrition is below par. A moderate amount of stimulant may be required; and if there are great daily fluctuations in the temperature, indicating the onset of pneumonic phthisis,

the pill of digitalis, quinia and opium (Niemeyer) is used three times a day.—*Can. Med. and Surg. Journal.*

Treatment of Hæmoptysis.

In the University clinic, at Charkow, it has been found that the tincture of the seeds of *Carduus Mariæ* has the best effect in spitting of blood. It has been used for more than a year and a half, and has succeeded in many cases where ordinary remedies failed. The dose is from 40 drops to a teaspoonful, repeated several times (*Allg. Med. Cent. Zeit.*, July 9, 1881).

Treatment of Hæmoptysis.

Dr. TAACKE, of Berlin (*Berl. Klin. Wochen.*, No. 6, 1881), having injected sulphate of atropia subcutaneously for eczema in a female patient ($\frac{1}{300}$ grain twice daily in distilled water for two days) noted that the menses, which had been very profuse, became moderate, and remained so. The same result he has seen follow five times in two other patients, and in a case of hemorrhage from the lungs the hemorrhage twice ceased immediately on the injection.—*Med. and Surg. Reporter.*

Local Treatment of Hay Fever.

M. DE BUDBERG, a Swiss observer, draws attention (*British Medical Journal*, July 2, 1881) to a simple, and, as he claims, efficient method of treating this distressing malady. The first case was observed by M. De Budberg in an Englishwoman, who had suffered from hay fever for twenty years. The treatment employed consisted of nasal irrigations of a solution of quinine (1 part in 750 of water). This irrigation brought away masses of brownish mucus, in which were found small round yellow corpuscles, of smaller dimensions than the blood-corpuscles. It did not contain either vibrios or bacteria. After two or

three douches the patient was perfectly well. The attack was arrested from that time. A solution of chlorate of potash was employed, and no relapse occurred, although the patient frequently passed flowering meadows. Every time that she attempted to suspend the treatment a relapse occurred, which, however, was promptly ameliorated by the use of the douche.—*Med. Record.*

On the Indications for the Treatment of Naso-Pharyngeal Catarrh.

On this subject Dr. Andrew H. Smith expresses himself as follows:—

1. Keep the parts clean.
2. Remove all sources of irritation resulting from occupation, residence, climate, etc.
3. Enforce attention to hygiene and to the general health.
4. If there is obstruction to nasal breathing, remove the obstruction.
5. If there is ulceration, use strictly local applications, with a view to healing.
6. If there is hypertrophied glandular structure, yielding excessive secretion, remove the hypertrophied portion.
7. If, after the above indications have been fulfilled, there is still hyperæmia, use mild astringents and sedatives, and such constitutional treatment as is thought to be indicated.
8. Cease treatment the moment there is no longer a definite indication for it.—*Med. and Surg. Reporter.*

DISEASES OF CIRCULATORY ORGANS.

Angina Pectoris.

Dr. MURRELL has tested nitro-glycerine in three severe cases, with a success, quite equal to that afforded by nitrite of amyl. He gives 1 m of a 1 per cent. solution every three hours on sugar or in a little water.

MEDICINE.

CONSTITUTIONAL DISEASES.

Treatment of Typhoid Fever.

Dr. H. V. FERRELL (*St. Louis Clin. Record*) says: The treatment of typhoid fever is quite satisfactory, the mortality in my experience barely exceeding two per cent. In the treatment there are three fundamental rules to be kept in view:

1. Put the patient to bed early, and enjoin the most absolute rest throughout the whole course of the disease. In all cases of doubt in the diagnosis, I advise the patient to take his bed. If it is not typhoid, rest is not apt to hurt him, and if it is, it may be the very means of saving his life. In every one of my fatal cases this rule was *not* observed. In two cases of death from perforation, one had been about with the fever on him for two weeks, the other three. In the one from hemorrhage, the young man tried for near three weeks to wear the fever out. I have lost no case where the patient took to bed early.

2. Early and judicious alimentation; by early I mean within the first forty-eight hours. The aliment should be highly nutritious, easily assimilated, in a liquid form, and given at regular intervals.

3. Use drugs only to meet indications, and with a well defined purpose and no longer than that purpose is subserved. The German specific treatment I believe to be utterly worthless, if not worse. If the temperature runs high, use quinia and digitalis in large doses, sponge the surface freely and frequently with equal parts of whisky and water, to which may be added a little muriatic

acid. To control the bowels and to correct the offensive odor of the discharges, bismuth and carbolic acid, or bismuth and liq. sod. chlorinati. For the vomiting, which is sometimes very troublesome, oxalate of cerium in 10 gr. doses, or calomel in doses of the $\frac{1}{10}$ or $\frac{1}{12}$ of a grain. For restlessness or sleeplessness, codeia has answered my purpose best. For intestinal hemorrhage, hypodermic injections of ergotine, or what answers just as well, Squibbs' Fluid Extract of Ergot. For great muscular or nervous weakness I have seen tr. nucis vomicæ, produce excellent results.

Finally, I have no sort of doubt as to the utility of alcoholic stimulants early and judiciously administered.

Transfusion of Blood for Hemorrhage in Typhoid Fever.

Dr. F. A. MAHOMED (*British Med. Journal*) gives two cases. The first was that of an unmarried man, aged 26, who was stout, rather bloated, and thoroughly out of condition. He passed through an anxious attack of enteric fever, complicated during the latter part of it by wakeful excited delirium, resembling that of delirium tremens, a complication not unfrequent during the defervescence of the specific fevers, and perhaps more especially liable to occur in persons addicted to the excessive use of alcohol. He relapsed on the twenty-fifth day of his illness; on the tenth day of his relapse, and the thirty-fifth of his fever, he had a severe hemorrhage, which recurred twice on the following day. Exhausted, anæmic, restless, with cold extremities, and a very small,

thready and often irregular pulse, about 160 per minute, he was evidently fast sinking, when transfusion was performed with the immediate result of bringing down his pulse-rate from 160 to 144. After this he rallied for a few days, and even gained ground so much as to give great hopes of his ultimate recovery. Six days after the operation, hemorrhage recurred to a small amount, which caused a sudden change for the worse; one or two more slight discharges of blood soon reduced him to a state of exhaustion, from which he could not recover. He died nine days after the operation, on the nineteenth day of his relapse and the forty-fourth of the fever.

The second case, male, married, was twenty-five years of age—a powerful, well-made man, who, during his attack of fever, suffered a probably irrecoverable injury by collapse of a large part of his right lung, while in addition to this he had severe general bronchitis. On the twenty-sixth day of his illness he, too, had a relapse. On the fifth day of his relapse, and the thirty-first of his illness, he also had a severe hemorrhage; four days later he had three more severe hemorrhages, and relapsed into a state of complete exhaustion and impending dissolution. On the following day, when he appeared to be *in extremis*, transfusion was performed with the best possible effects; for two days he rallied greatly, when, during the exceptionally cold weather, his bronchitis increased, and he died from the lung complication on the fifth day after the operation, on the fifteenth of the relapse, and the fortieth of his fever.

Dr. Mahomed gave some statistics showing that the average frequency of hemorrhage in enteric fever was about 7 per cent. of all cases, and that about 50 per cent. of these were fatal; that

more than half of the fatal cases of hemorrhage lost their lives as a direct result of the bleeding; and that in these cases more especially the operation might be called for. Each case must be judged on its own merits, and he would advise its performance whenever the patient was sinking into a dangerous condition, as a direct result of the loss of blood. He claimed that by means of it fatal exhaustion and syncope might be warded off, and time given for the action of remedies; a ready stimulant and food supplied to the heart and tissues; and the danger of destructive ulceration of the intestines during exhaustion and anæmia diminished. He advocated only direct transfusion of human blood by means of Aveling's transfuser, with a small expansion and no valves. —*Hosp. Gazette.*

Typhoid Fever Convalescence.

Dr. BRAVIE (*Gazette des Hôpitaux*) claims that the convalescence of typhoid fever is marked by the following phenomena: "(1) The pulse and temperature approximate the normal, but at times the pulse remains frequent; occasionally for a long time. (2) The weight of the body increases, and when it diminishes or remains stationary, some accident is to be feared. (3) The muscular force has a regular and constant daily increase. (4) Urea is excreted in large quantity when convalescence is confirmed, and when convalescence is nearly complete it diminishes. While not of positive value, these conclusions cannot fail to be of some use as cumulative evidence.—*Chicago Med. Review.*

Typhoid Fever.

Dr. BOUCHARD recommends that in using stimulants in typhoid fever, they should be mixed with antiseptic substan-

ces, in order that purulent infection may be prevented from the intestinal lesions, and gives the following formula : \mathcal{R} . Rum. $\frac{3}{4}$ iv. ; creosote, gutt., ij. ; phenic acid, gr. iv. ; salicylic acid, gr. xv. Small quantities of this or a similar antiseptic stimulant may be given as required.—*Le Concours Medical.*

Typanitis of Typhoid Fever and Enteritis.

Dr. MAURICE RAYNAUD recommends the following : (1) \mathcal{R} . Pulv. nucis vomicae, gr. jvss. ; pulv. anisi, gr. ijss. M.—Div. in two powders, one to be taken morning and evening. (2) \mathcal{R} . Pulv. carbonis ligni. Two tablespoonfuls during the day.—*Michigan Med. News.*

Malaria.

\mathcal{R} . Quiniae sulph., $\frac{3}{4}$ v. ; cryst. iodine, gr. xv. ; ipecac pulv., gr. xx. Triturate the iodine, add ipecac. and quinine, mixing the whole, which divide into 40 pills. Sig.—One pill half hour before each meal.—*Med. and Surg. Reporter.*

Recurrent or Obstinate Malarial Attacks.

Dr. JOHN H. POOL (*Virginia Med. Monthly*).

I have been more successful in the treatment of recurrent chills by the following plan of treatment than from any other : Give fifteen to twenty grains of quinia or cinchonidia three hours before the expected paroxysm. I prefer one large dose to the same quantity given in broken doses at intervals of an hour or two. One large dose will cause less distress to the patient than small doses at short intervals. By giving one large dose we will break up the paroxysm, for none of it will be eliminated by the kidneys until the work is done. But to prevent their return further treatment is required. On the critical days repeat the anti-periodic in ten-grain

doses. To reduce the enlarged spleen (which is nearly always present), and to bring the liver into its normal condition, I administer Lugol's solution with ten grains additional of iodide of potassium to the ounce, in five or ten drop doses before meals, and three to five drops of Fowler's solution after meals. Without these adjuncts the treatment is apt to prove a failure. On the fourteenth and twenty-first days give the anti-periodic again for a day or two.

For the last five years I have been using largely cinchonidia sulphate, and I have yet to discover that it is not equally as efficient, as a periodic, as quinia sulphate. In the convulsions of children, resulting from congestion of the brain in these disorders, I have found nothing better than a combination of chloral hydrate, bromide of potassium and sweet spirits of nitre in appropriate doses.

Treatment of Intermittent and Remittent Fever.

Dr. AUSTIN FLINT (*Med. Gazette*). I give at once five grains of quinine, and repeat the dose every four hours until slight signs of cinchonism are detected. I continue it in full doses till the paroxysm no longer occurs, and in smaller doses for a long time afterward. It is generally given by the mouth, but may be given by the rectum in double the quantity, by means of enemata. Or if these both be impracticable, by hypodermic injection, in doses about one-half less than by the mouth.

Many other remedies are used, among them are silicin, strychnia, ferrocyanide of iron, sulphate of berberin, nitric acid and the sulphites.

In effecting a cure, quinia acts as a toxical agent, destroying the low organisms on which the disease depends for its development.

We may sometimes abort a paroxysm

by full doses of opium, or by pilocarpine. Very favorable reports of the efficiency of this latter agent have recently been recorded. Any measure that will arrest a paroxysm may effect a cure. During the paroxysms our treatment must be palliative, using with discretion the means that the indications may suggest. Iron should be given for the anæmia attending the disease; nothing will diminish in size the enlarged spleen so speedily as quinia.

We have now to describe a much more dangerous form of this disease, namely, pernicious or congestive intermittent fever, the distinctive feature of which is its fatality. It may terminate in death in a few hours. It is rare in temperate, but frequent in tropical climates.

The only anatomical appearance that distinguishes it from the benign form is the more strongly marked melanotic character of the tissues. We must remember that the pernicious paroxysms may be preceded by several of a benign character.

There are several varieties of pernicious intermittent. We may have simply a condition of profound coma in the cold stage, death taking place before the stage of fever. Or the coma may be accompanied by delirium, vomiting, purging, and convulsions.

Again, there may be simply great prostration, or this may exist with hæmaturia.

In the stage of coma we must use external and internal stimulants, study the indications and treat accordingly. Our first object is to carry the patient safely through the first paroxysm, then to prevent its recurrence by quinine in full doses, pushed till cinchonism is produced. I give an adult 20 to 30 grains at once, and if a distinct impression is not produced in four hours I repeat the dose, bearing in mind that the drug may

be given in dangerous doses. Keep the patient quiet and warm, and when you expect another paroxysm give an opiate and try the abortive effect of pilocarpine.

Remittent Fever.—Simple remittent, often wrongly called bilious fever, is really a variety of intermittent fever. It commences as an intermittent, develops into a remittent, and is followed by an intermittent. The same cause produces both. The difference is that there is a period of remission instead of an intermission, which lasts from three to twenty-four hours, or longer, and may have the varieties of the simpler form of intermittent. It may be inaugurated by nausea and vomiting of bile, etc., but it is rare for typhoid symptoms to be developed.

Its anatomical characteristics are the same as those of intermittent. The disease seems to be more frequent in certain climates and certain years than in others. With reference to diagnosis, the remission will serve to distinguish it.

Treatment consists in the prompt administration of quinine.

There is a pernicious remittent fever to which the same remarks apply as to pernicious intermittent.

Treatment of Malarial Chill.

At the Bellevue Hospital the following means are, among others, employed to prevent malarial chill:

1. The hypodermic injection of pilocarpine, gr. $\frac{1}{4}$.
2. The inhalation of gtt. v. of amyl nitrite every twenty to thirty minutes.
3. The administration of chloroform and whiskey, of each $\frac{3}{4}$ ss.

The excessive diarrhœa of typhoid is said to be remarkably controlled by the administration of gtt. xx. of turpentine every two to three hours.—*Medical Record.*

Treatment of Diphtheria.

Dr. N. F. BROWN (*Detroit Lancet*) says: When called to see a child three of four years of age, the following was prescribed:

R. Chlorate of potash, 3 ss.; pure glycerine, 3 iij.; muriated tinct. of iron, gtt. xx.; water, add q. s. to make 3 iij.

M.—Sig. Give a teaspoonful every half hour, day and night, arousing the patient when necessary to do so.

For an adult, one drachm of the potash, with thirty or forty drops of the iron, one-half ounce of glycerine, water q. s. to make four ounces, and then given as in the case of the child.

This course of treatment will reduce the temperature, relieve the common symptoms of pain in the head, back, and extremities.

With this treatment, conjoined with concentrated nourishment, and quietude of the patient, kept in bed, I was pleased to see in many cases the membrane exfoliate in from two to seven days' time and not reform again.

Eserine in Diphtheritic Paralysis of the Ciliary Muscles.

Dr. THEOBALD reports a case of paralysis of the ciliary muscles (paralysis of accommodation) following an attack of diphtheria in a boy. There was also loss of power in the faucial muscles, and speech was very indistinct. The ciliary paralysis was complete. He gave the patient strychnia in one-thirty-second-grain doses for a week, with only slight improvement. He then, in addition to the strychnia, the dose of which was gradually increased to one-sixteenth of a grain, prescribed eserine locally (two grains to the ounce of water) twice a day for three days, then once a day for two days, making five days in all of

treatment by this agent. The result was a prompt and complete restoration of accommodative power and the recovery of perfect vision, which has remained permanent. There has also been improvement in the other paralytic symptoms.—*Maryland Med. Journal*.

On the Treatment of Diphtheria, Etc.

Dr. JOHN A. LARRABEE (*Med. Times*) says:

Muriated tincture of iron, freely and persistently given, should form the basis of your treatment; its astringent property tends to prevent the organization of the membrane, while its effects upon the constitution tend to sustain the life of the patient, and thus enable him to throw off the membrane.

Another point I wish to speak of is this: The use of alcohol has been brought forward as something new by the members of the medical profession. Any poison in the blood tending to destroy life by destruction of the blood-corpuscles, as well as by its debilitating effects upon local tissues, indicates a stimulant and a preservative. In alcohol we have the most powerful agent to prevent the destruction of animal tissues. Its stimulant property needs no comments. Give muriated tincture of iron, then, and alcohol, with nourishment, but give the iron according to Col. Mulberry Sellers' directions for the use of his eye. Give along with this a whiskey-toddy, a milk-punch, or, what is better, Christmas egg-nog, and don't withhold it out of fear of intoxication. The amount of alcohol that can be taken under these circumstances with immunity is astonishing. I have myself given a child, seven years old, a pint of whiskey in twenty-four hours, without producing any symptom of intoxication.—*Med. and Surg. Reporter*.

Treatment of Diphtheria by Cyanide of Mercury.

Dr. ROTHE (*Deutsche Med. Wochenschrift*) reports thirty-four cases of diphtheria successfully treated. He uses the cold pack, hourly changed, thrice daily, rapid pencilling of the gums, etc., with the following:

R. Acid. carbolic., pt. j.; spir. vini gal., pt. j.; tincturæ iodini, pt. j.; glycerinæ, pts. v.

Internally, the following:

R. Hydrarg. cyanid., centigr. 0.01; aquæ destillat., grm. 120; tinct. aconiti, grm. 1.

Misce.—Sig. Dessertspoonful every hour. For young children the dose is to be proportionally diminished.—*Medical Times*.

A Case Illustrating the Identity of Croup and Diphtheria.

Dr. T. F. PEARCE reports the following in the *British Medical Journal*:

A boy six years old returned to his home in the country, from having been to the Moorfields Ophthalmic Hospital, and undergone an operation for traumatic cataract. About a week later he complained of sore throat, and his mother states that he was ill and troubled with it for over a week. About ten days after his return from London his eldest sister was attacked; and a few days after the commencement of her illness, the mother, another son, and the baby were seized with it. The baby was a sickly, delicate child at the time, suffering from acute eczema of the head and neck. For two days, however, it became very ill, and could not be got to swallow. The throat was reddened and swollen, but there was no false membrane to be seen. After two or three convulsive fits it died quietly. The other sick members of the family, viz., the mother, eldest daughter, and one

son, were all feeling ill, and complained of their throats; but besides swelling and redness of the tonsils and palate, there was nothing suspicious to be seen. A day or two after the baby died, however, the boy, who was at the time ill in bed, became much worse, and false membrane of an unmistakable type appeared on the uvula, palate, and tonsils. Shortly after this another son was taken ill, but with only the sign of ordinary sore throat. Up to this time the only remaining member of the family (besides the husband) who had not been ill was a little boy aged three years. About a week after the baby's death, however, he was said to be poorly and complained of his throat. His symptoms gradually developed; he became hoarse, coughed a little, lost his appetite, and his mother said he seemed at times as if he was going to be choked. There was no membrane visible from the mouth, the throat being merely red and swollen. The child, however, when asleep, breathed noisily, as if there was some obstruction in the larynx. The mother stated he awoke during his sleep, had fits of coughing, with a "croupy" noise, and great difficulty to get his breath. He was rather better during the day. The case of this last child corresponds exactly with the disease so called "croup," whereas that of the other child—his elder brother—exactly corresponds with the ordinary form of diphtheria. The family, although not strong, have previously been in good health. These cases seem all to have occurred through the illness of the boy brought from London. There has been no other case of diphtheria in the neighborhood. In only one case has actual membrane been discovered; but the prostration, swelling of the glands in the neck, and other symptoms of diphtheria have been very marked. The

boy with so-called "croup" is just the age at which this disease occurs; the others may be said to be too old for "croup."—*Med. and Surg. Reporter.*

Acute Rheumatism.

Among the prevailing diseases, rheumatism, in some of its various forms, is reported by physicians from every section of the country. Some correspondents ask for a remedy that will quickly lessen the temperature in the early stage of the disease. During past years I relied principally upon some one of the special sedatives to control the circulation and prevent the retention of heat, and full doses of salicylate of soda (or salicylic acid) and salicin to lessen oxidation. And the results obtained were quite satisfactory—often completely relieving the rheumatic sufferer in from five to twelve days. But this treatment nearly always required to be supplemented by agents to stimulate secretion and excretion in order to free the patient's organism of the poisonous elements of waste; or else a subsequent attack was almost sure to follow, and especially if the patient was exposed to sudden atmospheric changes. Recently, I have thoroughly tested the efficacy of pilocarpus pinnatifolius, in the incubating stage of acute rheumatism, and obtained speedy and gratifying results. The administration of this drug (jaborandi) should be made before the temperature reaches 102 degrees; and if the patient complains of great soreness of the muscles, with diminished capillary elimination, free draughts of warm diluents should precede the remedy, and the patient's bedroom should be kept at a uniform temperature of about seventy degrees. Fl. ext. pilocarpus pinnatifolius, dose 3 ss.; and if free sweating does not result in thirty minutes, repeat with warm diluents, at short in-

tervals, until sweating ensues, after which the intervals should be lengthened to three hours, if a prolonged action of the drug is desired. However, a repetition is not often needed, as the temperature will usually be lessened one to three degrees in as many hours. A few doses of quinia sulph., or salicylate of soda will complete the cure. Many physicians withhold quinia until the temperature is quite under control, and by relying upon infinitesimal doses of aconite often fail to check the causes of the inflammatory process until the disease passes beyond their control, and requires from four to thirteen weeks for "a full run." The list of cases treated by jaborandi embraces four cases of "sciatica" (with a history of one to four attacks each). These proved very tractable after the "free sweat."—*Chicago Medical Times.*

Unique Case of Acute Articular Rheumatism.

A. VOELKEL.—(*Berl. Klinische Wochenschrift*) relates the following case:

A healthy boy, aged ten years, was suddenly attacked by acute articular rheumatism, involving both knees and the right hip-joint, and successively all the other articulations, the phalangeal joints alone escaping. Salicylic acid had no effect. After a week or two, some of the joints returned to their normal condition, whilst others, under new febrile excitement, advanced to suppuration. Thus, in succession, the knee, wrist, shoulder, and hip-joints were the seat of septic and disintegrating processes. Spontaneous dislocation of the left hip took place. At last one of the parotid glands sloughed, and exposed the entire superior maxilla, opening into the pharynx. Repeated hemorrhages accelerated the demise of the unfortunate patient.—*St. Louis Clinical Record.*

Practical Relations between Rheumatism, Gout, and Rheumatic Gout.

Dr. JONATHAN HUTCHINSON (*American Journal Medical Sciences*), makes the following propositions:

That rheumatism is, in the main, a liability to joint-disease, brought about by exposure to cold and wet, through reflex nervous influence (a catarrhal arthritis).

That gout is, in the main, a liability to joint-disease, brought about by certain articles of food, by defects of assimilation and of excretion. (A humoral arthritis).

That in each disease, although the joints suffer most prominently, they by no means suffer alone.

That in each, by transmission through many generations, a diathesis is formed which is heritable, and which gives peculiarity to the diseases from which its subjects may suffer, and which stamps them as "gouty" or "rheumatic."

That gout and rheumatism are very frequently present together. Rheumatism is very often met with without gout, but gout is seldom present without rheumatism. Sometimes the two exist side by side, and attack the same patient at different times, but more frequently they become mixed and produce a hybrid disease (Rheumatic gout).

In connection with hereditary descent, various maladies are to be affiliated with gout and rheumatic gout, which differ somewhat from both—certain forms of iritis; hemorrhagic retinitis; universal crippling rheumatism (chronic rheumatoid arthritis); some forms of glaucoma, lumbago, sciatica, and neuralgia; *nodi digitorum* and possibly hæmophilia.

Iodoform in Tubercular Meningitis.

Iodoform is very highly praised by Dr. COESFELD (*Deutsche Medicinische*

Wochenschrift). The strongest claim made for it is its success in tubercular meningitis. Of seven well pronounced cases of this disease, two (children) were definitely cured. The iodoform was used externally, mixed with collodion, in twenty per cent. solution, with the addition of some aromatic to disguise the odor. This was applied three times a day to the forehead, temples and nape of the neck, the previous layer being removed once a day by acetic ether. When applied to large surfaces, the collodion acts as a decided antipyretic, as may be readily shown by thermometric measurement.—*Chicago Medical Review*.

DISEASES OF THE NERVOUS SYSTEM.

Management of Hysteria.

Dr. J. S. JEWELL, in Holmes' System of Surgery, says, concerning this, that by removal from the influence of friends sympathizing too deeply; by providing a skilled nurse; by firmly, yet kindly teaching the patient lessons of endurance; by breaking up settled habits of invalidism; by improving nutrition by due attention to the condition of the alimentary canal; by simple, though good feeding; by careful massage; by securing an abundance of sleep; by the use of light sedatives, and, if needed, of anodynes, and the cautious use of tonics; by daily exposure to fresh air and sunlight; by keeping the patient from exciting company; by due attention to local disorders that may happen to complicate cases; by such means are cases of hysteria to be slowly, but, as a rule, certainly benefited.—*Ibid*.

Bromide of Ethyl in Epilepsy and Hysteria.

DRS. BOURNEVILLE and D'OLIER (*Le Progres Med.*) agree that hysterical attacks are generally easily arrested by bromide of ethyl. Attacks of epilepsy

may sometimes be arrested by giving the medicine from the tonic period; most frequently inhalation is of no benefit. In epilepsy the regular use of bromide of ethyl, administered in daily inhalations during a period of one or two months, diminishes very notably the frequency of the attacks.—*Therapeutic Gaz.*

Croton-Chloral Hydrate in Facial Neuralgia and Hysteria.

DR. C. J. FOX (*Medical Bulletin*) says: For some time past I have used, with special efficacy, croton-chloral hydrate in nearly all the cases which have recently come under my observation, of facial neuralgia (some seventeen in all), and my experience in successfully treating the affection by means of the drug have led me to give the results of my observation to the profession. I generally prescribe a full dose in this class of cases:

R. Croton chloral hydrate, 3 ij.; glycerine, 3 ij.; aqua fontana, q. s. 3 iv. M. Fiat solutio. Sig.—Ter in die.

In ordinary cases I give a teaspoonful three times a day. If the symptoms are quite urgent, I give a teaspoonful every two hours, until the pain is relieved. In hysteria, especially when convulsions come on, it is specially valuable. My opinion is that the drug, in small doses, produces, first, anæsthesia of the head before the rest of the body is affected. In large doses, the hypnotic effect is marvelous. Suffice it to say, its beneficial value is to be seen in all painful affections of the head, in just such cases. I have observed its efficacy as a therapeutic and remedial agent. Permit me to add, its primary action is clearly marked in producing anæsthesia of the head, and only after this does its influence extend to the organs of the body. Finally, its true value can only be weighed, not by individual experi-

ence, but by the general verdict of the profession.—*Med. and Surg. Reporter.*

Bromide of Sodium and Epilepsy.

Dr. HAMMOND'S experience has proved the following to be one of the best plans of treatment for epilepsy: Dissolve eight ounces of bromide of sodium in a quart of water. Of this take a teaspoonful three times a day. After three months add one teaspoonful more to the night dose, and after another three or four months add a teaspoonful to the afternoon dose also. At the expiration of a year do the same with the morning dose, and continue with this for a year or more thereafter. If no symptoms of the disease have meanwhile appeared then gradually reduce the doses, and at the expiration of the third year stop. The attacks do not usually return after this course of treatment. Ordinarily, however, patients stop the medicine after a month or two, and in such cases the attacks almost invariably return. It is then almost impossible to bring these patients under the influence of the bromides again. The doses will have to be at least doubled, and this may so derange the system as to make it impossible to take the medicine longer.—*Louisville Med. News.*

Gulf-Weed in Epilepsy and Obesity.

Gulf-weed, in doses of gr. ij. of powdered extract every two hours, has been successfully used by Dr. M. Milton in a case of epilepsy, combined with, and as he thought, dependent on obesity.

The gulf-weed is especially useful in the treatment of obesity. Combined with a milk diet and diminution in salted and solid food, it acts very rapidly in reducing flesh without weakening the patient. Gulf-weed is entirely distinct from fucus vesiculosus. — *Maryland Medical Journal.*

Sedative in Epilepsy.

R. Liq. atropiæ, 3 ij. Sig.—One drop in a tablespoonful of brandy and water night and morning.—*Med. Gazette.*

Sedative for Hysterical & Hypochondriacal Patients Suffering from Sleeplessness.

R. Ext. hyoscyami, grs. 40—60 ; camphoræ, lupulinæ, aa., grs. 20. Divide into 18 pills, and order three to be taken every night at bed-time.

Hysterical Hip-joint Disease Cured With the Magnet.

M. BRACHET (*N. Y. Med. Journal*). A girl eighteen years of age, of nervous temperament, and with a tendency to chlorosis, was seen, in 1879, complaining of pain in the right ovarian region ; even the pressure of her clothes caused great suffering. The daily application of a magnet during half an hour removed the pain after fifteen *séances*. Six months later she developed what was looked upon as a coxalgia. She was treated by rest for six months. At the end of this time there was anæmia, with loss of flesh. Exaggerated nervous sensibility, irritability, despondency, sleeplessness, and distaste for food. There was continuous violent pain about the right hip-joint, aggravated by any attempt to walk, increasing toward evening, but diminishing a little in the morning. There was hyperæsthesia of the thigh, greater when touched suddenly and over a small surface, less when pressed upon firmly and with the whole hand. There was slight pain at the inner aspect of the knee on the same side in the course of the obturator nerve ; there was also hyperæsthesia along the spinal column and in the left intercostal region. All of these symptoms were exaggerated during a menstrual period, which was always very painful, with an abundant flow. There

was no change in the color of the skin in the painful region ; no difference of temperature between the two hips. The thigh was flexed and abducted on the pelvis, without any crepitation on motion. There was no evening elevation of temperature. Considering the ovarian pain from which the patient suffered the absence of any hereditary or traumatic influence, the remissions of the pain, the slight pain caused by pressure on the trochanter major, the acute pain caused by simple pressure on the skin, the absence of pain under Poupart's ligament, the absence of any articular or circumarticular swelling, a diagnosis of hysteria was made, and the application of a magnet was determined upon. After the first two nights passed under the influence of a magnet placed five centimetres from the painful hip, sleep returned, and the character of the pain completely changed. The application was continued every evening. The pain diminished little by little (not suddenly, as we often see in hysterical coxalgia). After two months of this treatment the patient could run, jump, and dance without the least pain. M. Brachet does not think that the mental impression was the cause of the cure. The relief was slow and progressive, and should be entirely attributed to the application.

Localized Cerebral Lesions.

From the study of twelve cases of localized cerebral disease which he has published during the last four years, Dr. E. C. SEGUIN (*Journal of Nervous and Mental Disease*) draws the following conclusions :

1. The motor area of the cerebral cortex and allied white substance extends anteriorly as far as the lower half of the second and first frontal gyri, and posteriorly as far as the anterior part of the interparietal fissure.

2. The region lying between the limits indicated above, the middle regions of the hemisphere, on its convexity and (to a certain extent) on its median surface, including the posterior parts of the first and second, the whole of the third, frontal gyri, the whole of the ascending frontal and ascending parietal gyri, with their terminations in the longitudinal fissures known as the paracentral lobule, with probably the upper parietal lobe—all these cortical parts, with their associated segments or fasciculi of white matter, have strong motor functions, being in direct relation with the muscles of the face, tongue, arm, and leg.

The former of these statements is supported by three, the latter by the remaining nine of the twelve cases reported.

Included under the latter general statement a further and more elaborate induction is permissible :

a. The lower part of the third frontal gyrus is intimately connected with the organs of speech (and the function of language).

b. The middle parts of the ascending frontal and ascending parietal gyri are directly connected with the arm of the opposite side.

c. The upper or posterior part of the ascending frontal and ascending parietal gyri, and the paracentral lobule (also the upper parietal lobule?), are directly connected with the lower and upper extremities of the opposite side, and perhaps more closely with the leg.—*Med. and Surg. Reporter*.

Muscular Spasm.

Dr. F. A. SOUTHAM reports in the *Lancet*, the case of a woman who had suffered for twenty-three years from clonic spasm of the sterno-mastoid and muscles of the left arm. He exposed the spinal accessory nerve at the pos-

terior triangle of the neck, and stretched it with immediate relief. Later, although she was able to turn her head to the other side, the spasm returned, and an operation was made to excise a portion of the nerve. On cutting down it was found that the portion which had been stretched was atrophied. The second operation gave no relief. In another case occurring periodically, in a boy of fourteen, there was clonic spasm of the sterno-mastoid. The spinal was here stretched as in the former instance, with the result of giving great relief for a time, the intervals between the attacks being immediately lengthened to six weeks. After a time a relapse occurred, but later a very decided improvement again took place. In a third case—one of clonic spasm of the muscles of the left side of the face, in a woman of fifty-nine—the facial nerve was stretched. Paralysis first ensued, but this had begun to disappear five weeks after the operation, and the spasm was entirely relieved. The duration of this last case had been two years.

Chloral and Bromide of Ammonium in Febrile Delirium.

Dr. C. H. HUGHES (*St. Louis Medical and Surgical Journal*) says :

"An extensive experience with these therapeutic agents in the delirium of fever justifies its confident commendation to the practitioner of medicine; an experience begun many years ago at Fulton, with their use in the delirium of mania, and extended there and elsewhere to a delirium associated with all other forms of disease, from that of typhoid and the exanthemata to delirium tremens and aggravated hysteria. In fact, no drug, in hysteria, equals a full resistless dose of chloral, the patient usually awakening from her "tantrum," refreshed, rested and tranquil in her

nerve-centres, which for hours before were all unstable and unstrung.

"The true therapeutic principle in the use of these valuable agents is tranquilization and the recuperation and resistance to decay which the restraint exerted by them brings about. The ammonium bromides for use during the day, and the chloral once only at night. Twenty to thirty grains of the former, *ter in die*, and as small a dose of the latter as will induce sleep at night, and largely diluted with water, milk or beef-tea, the beef-tea being preferable in all typhoid states.

"While large doses of chloral are indicated in maniacal excitement, in febrile delirium only small doses are required.

"To periodically arrest cerebral disintegration in febrile delirium, at the natural time for sleep, is a point gained each day in the direction of restoration, as shown in the often apparent improvement of the patient after each waking, and enables the *vis medicatrix nature* to better fight the battle of life, with destructive disease."—*Med. and Surg. Reporter*.

DISEASES OF RESPIRATORY ORGANS.

Carbolic Acid in Whooping-Cough.

Dr. J. BAUGH states, in the *Canada Lancet*, that having recently had several patients suffering with whooping-cough, and having administered the usual remedies without getting the least benefit, he commenced giving carbolic acid and glycerine, in small doses, repeated every hour, which treatment yielded very satisfactory results. The paroxysms of coughing and the vomiting, which in some cases were very severe and frequent, were reduced almost to a minimum in less than twenty-four hours. For a child three years old, he gives the following:

R. Acidi carbolici, grs. iv.; glycer-

ini, 3 iss.; syr. simp., 3 iv.; aquæ ad 3 ij. M.

Sig.—A teaspoonful every hour.—*Med. and Surg. Reporter*.

Macdonald on Carbolic Acid in Whooping-Cough.

Dr. MACDONALD (*Edinburgh Med. Jour.*) says: That on extended trial he finds carbolic acid, in doses of one-fourth of a minim to a child of six months, one-half a minim for a year, and one minim for two years and upwards, to be the best remedy for whooping-cough. The whoop goes; the vomiting ceases; the paroxysms are modified in intensity and frequency. This result Dr. Macdonald believes to arise from an action similar to that of creasote on the motor fibres of the vagus to the stomach, and from a lowering of vitality of the specific germ of whooping-cough disease. This points to the antiseptic treatment of the zymotic diseases generally.—*London Medical Record*.

Picrotoxine in Night-Sweating.

Dr. F. R. HENRY (*Med. and Surg. Reporter*). I have exclusively employed the active principle of *cocculus indicus*, picrotoxine, in the treatment of night-sweating in phthisis and other diseases. My success with this substance has been decidedly superior to that previously obtained by the mineral acids, belladonna and ergot, singly and combined.

My attention was first called to this use of the drug by a quotation from an article in the *Practitioner*, by Dr. Wm. Murrell. The dose used by Murrell was from gr. $\frac{1}{100}$ to $\frac{1}{60}$; the latter amount, four times a day, being the largest dose administered by him. My custom has been to give a pill containing gr. $\frac{1}{80}$ at bedtime, which dose may be repeated once or twice during the day in obstinate cases.

As above intimated, I have not employed this drug solely in the night-sweats of phthisis. I recall a case of chronic pleurisy in which, the effusion having been absorbed, convalescence was unaccountably retarded and prostration was so extreme that a latent, incipient phthisis was suspected. The skin was bathed in perspiration during the greater portion of the twenty-four hours, and this being the only discoverable morbid condition, I resolved to treat it with picrotoxine. It was promptly checked and convalescence set in immediately.

I have employed the drug in nearly one hundred cases.

Antiseptic Inhalation in Pulmonary Affections.

I. G. SINCLAIR COGHILL, M. D., F. R. C. P. Ed. (*British Med. Journal*).

The objects of treatment are: 1. To lessen secretions. 2. To promote evacuation of what secretion is formed. 3. To disinfect the air which may pass into surrounding or deeper healthy portions of the lungs. Again he says: "Besides acting as disinfectants, antiseptic inhalations promote expectoration by increased energy of expiratory acts. The apparatus is extremely simple. It consists of a space for a pledget of tow or cotton wool, inclosed between the perforated surface of the respirator and an inner perforated plate, which can be raised so as to permit the tow to be saturated with the antiseptic solution. Elastic loops are attached to pass over the ears and retain it in position. The inhaler may be procured either plain or of a slightly smaller size, and covered with black cloth for wearing out of doors. The pledget of tow, which may be changed once a week or so, sprinkled with from ten to twenty drops of the antiseptic solution, from a drop-stoppered vial, twice a day at least, accord-

ing to the extent to which the inhaling may be carried on. Of this the patient is the best judge, and the length of time and quantity of solution should be regulated by tolerance and effect. The most important times for inhaling are for an hour or so before going to sleep at night, and after the morning expectoration, which leaves the suppurating surface or cavity dry to be acted upon—disinfected, so to speak—by the antiseptic vapor. A great many of my patients have of their own accord come to use the respirator almost continuously day and night from their experience of its good effects. I attach the utmost importance to the mode in which the respiration is conducted while inhaling. The patient should be carefully instructed to respire through the mouth alone, and expire through the nose. In this way the breath is drawn through the saturated tow in the perforated chamber of the inhaler, and passes directly into the lungs laden with the antiseptic materials. Expiring through the nose only, necessarily involves a complete circulation of the medicated air. The breathing should be short at the beginning of the inhalation, but gradually deepened, so as to displace and effect the residual air in the more distant portions of the lungs. This form of respiration itself is not only of great use in favoring the circulation of the blood in the lungs, and thus aiding local and general nutrition through the fluid, but it helps very much the expulsion of the sputa by means of the increased energy and thoroughness of the expiratory acts.

After many trials of the now formidable list of antiseptics, I find that carbolic acid, creosote and iodine, in combination with sulphuric ether and rectified spirits of wine, are the most efficacious and satisfactory. The want of

volatility in boracic, salicylic and benzoic acids, and their salts, proves a bar to their employment by this method. Dr. Horace Dobell, who has had a very favorable experience of this treatment, writes to me that he has found thymol, in the form of Shirley's thymoline, very grateful and efficient in many cases where the smell of carbolic acid and creosote was intolerable either to patients or to their friends. Of the three antiseptic agents I chiefly use, I find iodine most useful in the second stage of phthisis, when the expectoration is passing from the glairy into purulent character. I use the tincture for inhaling purposes made with sulphuric ether instead of spirits of wine, and this ethereal solution has a singularly soothing effect on the cough and pulmonary irritation. In combination also with carbolic acid, as carbolized iodine, or iodide phenol, it is extremely useful in the purulent expectoration accompanying the resolution of pneumonia, both catarrhal and croupous. In the stage of excavation, whether tubercular or pneumonic, the combination of iodine with carbolic acid and creosote is most potent. The acid seems to have the greater influence in checking the amount and purulent nature of the sputa; while creosote acts merely as a sedative in the cough, apparently by reducing the irritability of the pulmonary tissues. The addition also of varying proportions of sulphuric ether and chloroform greatly assists in soothing and allaying irritation. These combinations also act frequently like a charm in the profuse expectoration of purulent bronchitis, as also in bronchial asthma.—*Canada Medical and Surgical Journal.*

Mixtures for Diseases of the Respiratory Organs.

MIST. AMMONII CARBONATIS.—℞. Ammonii carbonat., $\mathfrak{z}\frac{1}{2}$; syr. senegæ, fl.

\mathfrak{z} iv.; syr. ipecac, fl. \mathfrak{z} ij.; syr. tolut., fl. \mathfrak{z} iv.; ext. glycyrrh., $\mathfrak{z}\frac{1}{2}$; aquæ cinnam. q. s. ad., fl. \mathfrak{z} iv. Mix. Dose: a teaspoonful for children.

MIST. AMMONII CHLORIDI.—℞. Ammonii chloridi, $\mathfrak{z}\frac{1}{2}$; potassii chlorat., grs. xl.; syr. senegæ, fl. \mathfrak{z} iv.; syr. ipecac, fl. \mathfrak{z} iij.; syr. tolut., fl. \mathfrak{z} v.; ext. glycyrrhizæ, \mathfrak{z} j.; aquæ cinnam., q. s. ad., fl. \mathfrak{z} iv. Mix. Dose: a teaspoonful for children.

MIST. EXPECTORANS.—℞. Ammonii carbon., grs. xxxij.; ext. senegæ fl.; ext. scillæ fl. $\mathfrak{a}\mathfrak{a}$ fl. \mathfrak{z} j.; tinct. opii. camph., fl. \mathfrak{z} vi.; aquæ, fl. $\mathfrak{z}\frac{1}{2}$; syr. tolut., q. s. ad., fl. \mathfrak{z} iv. Mix. Dose: a teaspoonful.

MIST. ACIDI HYDROBROMICI.—℞. Acid. hydrobrom. dil. (34 per cent), fl. $\mathfrak{z}\frac{1}{2}$; spts. chloroformi, \mathfrak{m} 20; syr. scillæ fl. \mathfrak{z} j.; aquæ q. s. ad., fl. \mathfrak{z} j. Mix. Dose: to be taken twice or thrice daily for colds.

COUGH MIXTURE.—℞. Syr. tolut., syr. pruni virg., tinct. hyoscyami, spts. ætheris co., aquæ, $\mathfrak{a}\mathfrak{a}$ fl. \mathfrak{z} j. Mix. Dose: a teaspoonful.

COUGH MIXTURE FOR ADULTS.—℞. Ammonii chloridi, \mathfrak{z} j.; spts. ætheris co., fl. \mathfrak{z} vi.; syr. pruni virg., fl. \mathfrak{z} ij.; aquæ q. s. ad., fl. \mathfrak{z} iv. Mix. Dose: a teaspoonful.

COUGH MIXTURE FOR INFANTS.—℞. Tinct. opii camph.; spts. ammon. arom., $\mathfrak{a}\mathfrak{a}$ fl. \mathfrak{z} j.; ext. ipecac. fl. $\mathfrak{z}\frac{1}{2}$; syr. pruni virgin, fl. \mathfrak{z} j.; aquæ q. s. ad., fl. \mathfrak{z} j. Mix. Dose: a teaspoonful.—*Hosp. Gazette—Quar. Epit.*

Cough Mixture in Phthisis.

℞. Ammonia carb, \mathfrak{z} i.; codeia, gr. vi.; etheris chlorici, \mathfrak{z} iss.; acid hydrocyn dil., \mathfrak{m} 10; syrup scillæ co., \mathfrak{z} iij.; mucil. acaciæ, \mathfrak{z} i.; syrup tolu, \mathfrak{z} iij. M. Teaspoonful every three or four hours. Keep well corked.—*New Eng. Med. Monthly.*

The Local Application of Chloral Hydrate in Throat Affections.

In a paper published in the *Detroit Lancet*, for July, 1881, Dr. G. A. COLAMORE speaks of a species of sore throat, characterized by moderate swelling of the tonsils and adjacent mucous membrane, pain in deglutition, and a peculiar cherry-red or purplish-red hue of the tonsils and pharynx. On the tonsils appear spots of whitish or yellowish white color, the size of a grain of corn or less. These are composed of the aggregated secretions of the tonsillar glands, and are readily detachable, leaving the mucous surface unabraded. There is, moreover, a moderate, sometimes high, grade of fever, and decided prostration of the system. The disease is properly a follicular tonsillitis, though the inflammation is not confined to the tonsillar surfaces, but affects the palatine and pharyngeal mucous membrane also, and is liable to be mistaken for and called diphtheria.

In these cases, combined with systematic remedies, chloral acts in a kindly manner as a local application, either as a gargle, a grain or two to the ounce of water, frequently used, or in a stronger solution applied with a camel's hair brush or a swab. A small quantity of the gargle may be swallowed after each gargling, in order to apply it to the lower pharynx. Employed in this way the author has found chloral a very valuable remedy.—*Med. and Surg. Reporter*.

Bicarbonate of Soda in Tonsillitis.

M. GINÉ, Professor of Clinical Surgery, at Madrid, affirms that the repeated application topically of bicarbonate of soda, is of incontestable efficiency in tonsillitis. The powder may be projected through a tube on to the inflamed parts or applied directly with the finger.

The relief is often immediate, and the cure often rapid, sometimes requiring but twenty-four hours. The application is rarely inefficacious and often aborts the disease in its prodromal stage.

M. Giné also considers these applications of great benefit in hypertrophy of the tonsils, often obviating the necessity of amygdalotomy.—*Ibid*.

Sedative in Asthma.

R. Spts. ammon. aromat, 3 ij.; tinct. lobeliæ æther, 3 3-6; tinct. aconiti, m. xxx.; aquæ camphoræ ad, 3 viii.

M. Sig.—One-sixth part twice or thrice daily.—*Med. Gazette*.

Spasmodic Dyspnœa.

R. Codeia, gr. ½; pil. assafœtidæ co., gr. v.

M. Make a pill, to be taken at bedtime.—*Ibid*.

Catheterism of the Trachea in Croup.

A correspondent writes (*British Medical Journal*), that he was called to a girl 2½ years old, for croup.

It was evident by the pulse, which was about 150, and almost imperceptible, that unless some relief could be given, the end was not far off. The face gradually became pale, and wore a distressed expression, and the lips were of a livid blue color. As the mother objected to tracheotomy, and as emetics, hot baths, and the ordinary routine treatment, had been previously tried, I introduced a large (No. 12) gum-elastic catheter into the trachea, with less difficulty than I anticipated — having first gagged the child's mouth with a cork, for the want of something better, and depressed the tongue with a spoon. After a severe paroxysm, she succeeded in getting a pretty good breath, and the next expiration was followed by the ejection of muco-purulent *débris* and sticky phlegm

through the tube. In about ten minutes these convulsive efforts ceased—the child, in the meantime, getting a good amount of air into her lungs. In half an hour her face was flushed, but had lost its lividity, and the breathing was fairly comfortable. The tube was retained by tape tied round the child's neck, and was removed twenty-four hours after its insertion, when the temperature had fallen to 100° Fahr. and the pulse to 110. Five days later she was running about the house, not much the worse for her dangerous illness. I observed hardly any difficulty in swallowing liquids after the first two or three attempts, when the tube had been introduced.—*Med. and Surg. Reporter.*

Relaxation of Uvula—Its Influence on Phonation.

Dr. LENNOX BROWN condensed an article in *London Medical Record* on the above subject, by Dr. Labus.

Dr. L. finds *relaxation of the uvula* a frequent cause of impaired voice. Impaired phonation, depending on this cause, is not so much due to *elongation* of the uvula as to the difficulty which, on account of its relaxed condition, the patient undergoes in making various movements of the soft palate during the formation of different sounds.

Relaxation of the uvula is of two kinds, of which infiltration and hypertrophy of the submucous tissue is the kind most commonly seen, accompanied not unfrequently by hypertrophy of the azygos muscle; the second kind is due to paresis or even complete paralysis of the same muscle. It is this last-named form which often escapes observation, for the uvula is apparently in a normal condition, and the laryngoscopic mirror, applied to discover lower down the voice-defect, conceals the fact that the

uvula remains immobile during production of the emitted notes.

Among exciting causes must be noted the diffusion of a coryza, irritations produced by alcoholic drinks, and particularly by tobacco, weeping, singing from the throat, and abuse of the timbre *sombré*.

From his experience, Dr. Labus believes only in a radical cure, namely, that of removal of so much of the relaxed uvula as is deemed necessary. In no case should the ablation be entire, but merely sufficient to restore to the resonating portion of the organ its normal volume and form. He has performed many of these operations, and his patients have invariably assured him of decided benefit.

DISEASES OF DIGESTIVE ORGANS.

A Dinner Pill.

FOTHERGILL, in *London Practitioner*. Ipecacuanha forms a portion of a good old-fashioned dinner pill; and betwixt its direct action upon the gastric mucous membrane and its action on the liver as an hepatic stimulant, it must come into use again before long. A dinner pill of

Pulv. ipecacuan. gr. j.; strychniæ, gr. $\frac{1}{2}$; ol. pip. nig., ℥ ij.; pil. al. et myrrh, gr. ijss. every day, will often produce excellent effects. Then arsenic may be taken, as three drops of Fowler's solution after dinner, or in the above pill, substituting the same dose of arsenic for the strychnine.—*Can. Jour. Med. Sciences.*

Anti-Emetic.

DR. RANDOLPH, in *Medical Brief*, suggests the following:

℞. Creasote, 20 drops; acet. acid, 40 drops; morph. sulph., 2 grains; aq. puræ, 2 ounces.

M. Sig.—Dose for an adult, teaspoonful in a little water.—*Chicago Med. Times.*

M E D I C I N E .

CONSTITUTIONAL DISEASES.

Eucalyptus Globulus in Typhoid Fever.

Dr. BENJAMIN BELL, F.R.C.S.E.
(*Edinburgh Medical Journal*):

After mentioning in a previous paper the remarkable benefit which, in my experience, had attended the administration of the tincture of the *Eucalyptus globulus*, or blue gum, in certain cases of what appeared to be very formidable disease of the stomach, I suggested that the same remedy might be found advantageous in cases of typhoid fever. My grounds for forming this anticipation are obvious enough. The drug possesses *antiseptic* qualities; it acts, as we have seen, beneficially upon the lining membrane of the stomach, perhaps of the duodenum. The characteristic lesion to be chiefly dreaded in typhoid fever is an irritated condition, a congestion, an inflammation, passing into ulcers or sloughs of the small follicular glands of the intestinal canal.

Ever since venturing to make the suggestion referred to, I have kept it in view, prescribing a teaspoonful of the tincture of *eucalyptus*, well diluted, at regular intervals of three or four hours, in all the cases of typhoid fever which have occurred. My distinct impression is that, as a rule, the duration of the disease has been shortened, and the tendency to diarrhoea diminished. If mixed with a large wineglassful of water, the medicine is far from disagreeable to the patient, and may be steadily administered in the intervals of nourishment without becoming irksome. By

food, I mean milk and lime-water. As each dose of the tincture contains a drachm of spirits of wine, it is worthy of consideration that we are, in fact, giving a slight stimulant, not only well diluted, but possessed of a medicative property at the same time. This may, therefore, come in lieu of those other stimulants so often deemed desirable, at least in the advanced stages of the fever, while, in the intervals of the bland, milky nutriment, it will be brought into immediate contact, as an antiseptic, with the seat of threatened ulceration and sloughing.

In private practice, with a comparatively small number of cases, it would be rash to speak dogmatically as to the results of treatment; but a reliable opinion might be arrived at, were physicians connected with a large hospital which admits fever cases to employ the remedy in every *alternate* case under their care. If those patients who got the medicine were found—after its employment in a considerable number of cases—to have made more rapid recoveries with fewer bad symptoms than those from whom it was withheld, it would be reasonable and safe to draw an inference in its favor.

I may mention that my confidence in the *eucalyptus*, in cases such as those formerly described, continues unabated. Indeed, it has been strengthened, not only by the results in cases coming under my own observation, but also by several aggravated examples throughout the country, reported to me by the first patient to whom I administered it.—*Med. and Surg. Reporter.*

Phenic Acid in Typhoid Fever.

Mr. VAN OYE has lately finished an interesting thesis on the above subject, and these are his conclusions, as published by *Paris Médical*.

1. Phenic acid acts as a poison on the nervous system, and possesses, to a high degree, the faculty of reducing temperature, both in man and the higher animals.

2. Doses having no appreciable effect on the normal temperature are sufficient to reduce the febrile temperature.

3. This reduction takes place in all fevers, whether simple phlegmasias or infectious pyrexias.

4. Its effects appear a few moments after the medicine has been taken; their range is from 1° to 3° Centigrade, according to the dose given, and they continue from one to three hours.

5. Its action is probably due to the loss of caloric resulting from cutaneous hyperæmia, and the more or less abundant sweats coinciding with its production.

6. When the antipyretic effects of a dose are exhausted, a chill supervenes, all the febrile phenomena return, and the temperature suddenly rises to, or even beyond, its former degree.

7. A fresh dose will counteract this paroxysm, or prevent its return, if administered in time.

8. Doses that are sufficient to produce all the required antipyretic effects do not exercise any immediate noxious or toxic action on the patient.

9. Fifty centigrams (gr. viiss.) administered *per rectum*, are in all cases sufficient at the outset. In general, the dose can be progressively increased until it reaches two grams *pro dosi* (3 ss.), and twelve grams *pro die* (3 iij.)

10. A dose of one gram (gr. xv.) has, in some special cases, lowered the tem-

perature down to 34.5° . This exaggerated reduction has, in no case, been attended with any evil results for the patient.

11. Pulmonary congestions are the danger to be feared and avoided.

12. Albuminuria, polyuria, and fatty degeneracies are the possible effects which may result from large and long-continued doses.

13. The antipyretic properties of phenic acid should be reserved to be used against hyperthermia in continuous fevers, or paroxysms in intermittents.—*Ibid*.

Typhoid Fever.

Many localities are, and for some time past have been, visited with rather an unusual amount of typhoids. This city (Indianapolis) has had, and is still having, a liberal share of it; though rather of the endemic character. Indeed, we have doubts as to whether the disease ever prevailed in any other form. But whether it does or not we shall not attempt to discuss at present, but rather to call attention to the prophylactic treatment of the disease in its formative stage. The premonitory symptoms of an idiopathic case are too well known among intelligent practitioners to require repetition. And in the incipency of the disease we have, for over eight years, adopted the use of aconite to abort the disease. For an adult we prescribe:

R. Fld. ext. aconite, fol., gtts. viii.; water, $\frac{3}{4}$ iv. Sig.—A teaspoonful every hour.

Keep your patient quiet, observe cleanliness of person and clothing, avoid all kinds of exposure and allow a generous diet of a nutritious but non-carbonized character, and in at least a large majority of cases you will succeed. Do not say, as we have had some say to

us, "O, the hygienic treatment is what does the work," for although it has its place, and an important one, too, the aconite is *the* important remedy, and without it your cases will run through all the stages of a regular typhoid fever. The greatest difficulty in this treatment is you don't get the cases in time. Many of the cases are so mild in their incipency that, where the patient is of a stirring and energetic nature, the premonitory symptoms fail to attract attention, and the ushering in of the second stage is required before the physician is consulted.—*Ind. Med. Jour.*

Vidal on Turpentine Compresses.

M. VIDAL, in a communication to the Therapeutical Society of Paris (*Gaz. Hebdom. de Med. et de Chir.*), reminded the society that in 1871 he had recommended the use of compresses of flannel, wetted with turpentine and covered with oiled silk. If the compress remain *in situ* for more than half an hour, vesication is generally obtained. The intensity of the revulsion may, however, be diminished by not putting on any impermeable covering, such as oiled silk, and allowing the turpentine to evaporate freely. M. Vidal attributes the remarkable success which he has obtained in cases of peritonitis not of a puerperal character, not only to the energetic revulsory character, but to the absorption of the turpentine by the skin; the pulse rises, the general state and facies rapidly improve, and cure is abundant in cases which seemed desperate. He has also obtained excellent effects in the broncho-pneumonia of infants.—*Lond. Med. Record.*

Aspiration of the Bowels in Peritonitis.

Dr. D. M. WILLIAMS (*Dublin Journal of Medical Science*): The patient was a

boy of thirteen. We quote the most interesting part of the history:

His condition was now alarming; the pulse was, for the first time, irregular and compressible—144 to the minute; breathing very shallow; eyes sunken; cheeks hollow; tongue dry; constantly moaning with pain—evidently dying. He placed his hand on the epigastrium, and said the pain was smothering him, no doubt from pressure upward of the diaphragm interfering with the action of heart and lungs. The abdomen was arched from the xiphoid appendix to pubes, the least attempt at percussion causing great agony. I determined to aspirate him, and passed the finest needle into the transverse colon; and, on turning the tap, a great quantity of flatus rushed through, followed by three ounces of fluid fæces, which gave him great relief, but did not perceptibly diminish the size of the abdomen. Fearing the needle was blocked, I withdrew it, and found such was not the case. I evidently emptied this portion of the colon. Having washed the needle, I pierced the ascending colon; another rush of flatus took place, followed by eight ounces of fæces. I repeated the operation on the descending colon, with the same result. There was now very decided diminution of distention and relief of pain; still he complained bitterly of a spot just below the navel, which was quite tympanitic. Taking care to avoid the bladder, I pierced probably the ileum; more flatus escaped, with about half an ounce of fluid fæces. He was now much relieved; pulse had fallen to 96; breathed deeper. 10 P. M.—Much the same as after the tapping; expression of face less haggard; pulse 120, full and soft; temperature 102°; passed water freely, and without pain, an hour after the tapping. To take pulv. Doveri, gr. 10, h. s. From this

time, his progress toward recovery was steady.

Tannin in Diphtheria.

Dr. A. WYNN WILLIAMS (*Brit. Med. Jour.*) claims for the local application of tannin all the value he maintained this drug possessed in 1867, in a paper read before the Obstetrical Society on the treatment of diphtheria. The deposit characteristic of the disease is almost instantly removed by the free application of a solution of—tannic acid, two drachms; rectified spirits of wine, two drachms; and of water, six drachms.—*Can. Jour. Med. Sciences.*

Lemon Juice in Diphtheria.

Dr. J. R. PAGE, of Baltimore (*Med. Rec.*) invites the attention of the profession to the topical use of fresh lemon juice as a most efficient means for the removal of membrane from the throat, tonsils, &c., in diphtheria: In his hands (and he has heard several of his professional brethren say the same) it has proved by far the best agent he has yet tried for the purpose. He applies the juice of the lemon, by means of a camel's hair probang, to the affected parts, every two or three hours, and in eighteen cases in which he has used it the effect has been all he could wish.—*Med. and Surg. Reporter.*

Can a Threatened Attack of Diphtheria be Averted?

Dr. ALFRED SHEEN, Surgeon to the Cardiff Infirmary, writes to the editor of the London *Lancet* on this important subject. His question is based on this fact: He was called to see a young woman who had nursed her brother through a fatal case of diphtheria. Four days after his death she was seized with general malaise, shivering and thirst,

Pulse, 144; temp., 103.4°. She did not complain of her throat, which, on examination, presented a normal appearance. She was given twenty-five grains of ipecacuanha powder at once, and one minim of the tincture of aconite every quarter of an hour, for the first hour, and every hour afterward. The next day her pulse was 94 and temp. 99.8°. On the next day her throat was painful and congested, but no patches. She was ordered:

R. Liq. ferri perchlor., f 3 iv.; potass. chlorate, 3 ij.; glycerinæ, f 3 ij.; aquæ, f 3 vj. M.

Sig.—f 3 ss. every four hours, in water

Two days afterward pulse was 76 and temp. 98°. Congestion gone and the girl said she was quite well. Dr. Sheen then asks: "Was this woman, when I first saw her, suffering merely from a sharp attack of febricula, brought on by fatigue, anxiety about her brother, and subsequent exposure at the funeral, or was she in the early stage of diphtheria?" He adds that, "As a rule, specific febrile diseases are not averted by treatment, but may that not be because we do not get hold of the disease early enough." (?)—*Med. & Surg. Reporter.*

Treatment of Diphtheria.

Dr. F. W. THORNHILL (*N. O. Med. Journal*):

I believe there are cases in which the powers of assimilation are so enfeebled as to render the administering of iron totally inadmissible when its use tends still further to incapacitate the stomach for the appropriation of other remedies and of food. I believe if there is any remedy that tends directly to eliminate the poison from the system, it is Iodide of Potash. I always, therefore, give two or three grains every three or four hours, combined with four or five grains chlo. potass., alternated with tinct. iron and

clo. potass., also using sulph. quinia, as the case requires.

Such, in the main, is the plan of treatment which has given me the most satisfactory results in the treatment of diphtheria. I have no faith in the use of local remedies to control the amount of exudation. Lately some physicians are claiming good results from the use of salicylic acid, as a local application, in controlling the exudation. I have had no experience with it myself, and am not prepared to speak for it.

**In Extreme Debility and Mental Depression
After Choreæ, Diphtheria, etc.**

℞. Micæ panis., grs. lx.; aquæ destillatæ, q. s. to make a mass. Then add phosphori, grs. j.

Mix thoroughly, divide into twenty pills, and order one to be taken thrice daily.—*Med. Gazette.*

Small-pox, followed by Ataxy.

Dr. G. C. HENDERSON (*Lancet*) reports a case of small-pox followed by ataxy. The patient, G. A., aged thirty-six, was admitted to the St. Pancras Tent Hospital, on May 29th, 1881. His temperature, which had ranged from 100° and 102° F., rose suddenly on May 31st, reaching in a few hours 107.8°, and he was then immersed in a bath at a temperature of 68° for fifteen minutes. His temperature was then 96°, but it rose gradually in the course of the next eighteen hours to 104.4°. The bath was repeated. No hyperpyrexia or other complication followed, but convalescence was much protracted, large bullæ having formed on the soles of both feet, leaving scales, which separated very slowly. On July 18th, when he began to get up, he suffered from numbness and tingling of the feet, legs and hands; the knee jerk and ankle clonus, as well as the skin reflexes, were

absent, and he lost his balance when his eyes were closed. After leaving the hospital he attended as an out patient. He slowly gained power in his legs, but when last seen the knee-jerk was still absent. Dr. Henderson refers to similar cases recorded by others, and considers the lesions causing the patient's symptoms probably analogous to those found in diphtheritic palsy and other forms of paralysis noted after acute diseases. They differed from those of true locomotor ataxy in the more favorable course which they took, ending in the majority of cases in recovery. Dr. Whipple had had two cases similar to Dr. Henderson's. Neither of them was treated with the cold bath, so the suggestion that the ataxy had had anything to do with the cold bathing might be dismissed. Both patients talked in a peculiar manner. Another point to be noticed was the irritability of temper which he thought most of these patients suffered from.—*Med. and Surg. Reporter.*

Small-pox—Cooling Treatment.

Dr. HIRAM CORSON (*Country Pract.*) says: May 24, I was called to a young man who had been hired to work on a farm only two days before. As soon as he reached his employer's home he complained of backache, headache, etc., and was unable to work. I found him very feverish and with an eruption over his face and neck, and a red, heated state of the body. I diagnosed small-pox. The farmer and his wife were greatly alarmed and refused to have anything to do with nursing him; no one else could be got and so the whole affair devolved on me. I kept the windows open, had him covered only by one sheet, gave him freely to drink of cold water (spring water) and a teaspoonful of cream of tartar in a tumbler of water every three

hours until it should purge him. It used to be forbidden to give even a laxative in measles, or any other eruptive or pustular disease, for fear it would prevent the appearance of the eruption or pustules; I have no fear of that kind. During four days I continued this treatment without giving any food; then I began to give milk. Why did I not begin sooner? Because in this disease as in many others where fever prevails, even the thought of taking food is disgusting. The time in which patients (febrile patients) loathe food, lasts but a few days, then there is tolerance of it and soon a pleasure in taking it. Every morning after I began to give him food, I had a quart of milk brought to me, of which I gave him a tumblerful, and directed him to drink all the rest during the day, with plenty of ice water. At 6 p. m. I had another brought to him for the night. He was very full of pustules, but all went well, and on the 15th of June I paid my last visit, and he was walking about the room. Not a particle of food entered his mouth but the milk. He arose from his bed free from disease and he has been perfectly well ever since. If I could have charge of one who had never been vaccinated, but had been exposed to the contagion of small-pox, I would prepare him, by mild laxatives, a weak solution of Epsom salts, or teaspoonful doses of cream of tartar, in half a tumbler of water every four hours, or often enough to move the bowels, by a light diet and abstinence from all stimulating drinks. If this could be continued for a few days, I would expect him to have a mild disease; but if I should not be called until the pustules had appeared, I would, if the heat were great, use the same means—cooling laxatives, cold drinks, no food for a few days, cool sponging to the body or head, or both, if the temper-

ature runs high, almost no covering, a good breeze of air blowing over him if the weather were warm.

Lung Troubles in Variola.

The Pulmonary lesions of variola are studied by M. BREYNÆRT (*Thèse de Paris*, 1880); he describes the pustules of the trachea and bronchial tubes, which do not descend to the smaller tubes. He then considers the actual pulmonary alterations, which are, in order of frequency and gravity: (1) Splenization or inflammatory congestion. (2) Spleno-pneumonia. (3) Broncho-pneumonia, with disseminate or confluent points of inflammation. (4) Capillary bronchitis. All of these alterations resemble very much, anatomically and clinically, those of the same kind found in typhoid fever, and have the same causation, which is the adynamic vasomotor paralysis and the blood infection.—*Med. and Surg. Reporter*.

In Tuberculosis, Rickets and Scrofula.

℞. Phosphori, gr. j.; olei morrhuae. ℥ vi. M. Sig.—One or two teaspoonfuls three times a day after food.

℞. Phosphori, gr. j.; olei amygdalæ, ℥ iij. M. Sig.—Teaspoonful in a glass of barley water three times a day.—*Med. Gazette*.

In Scrofula with Low Nervous Vigor.

℞. Ferri phosphat., grs. xl.; acid. phos. dil., 3 iss.; syr. aurant. flor., ℥ j.; muc. tragacanth, ad. ℥ viii. M. Sig.—One-sixth part three times a day.—*Ibid*.

Obesity, its Causes and Cure.

DR. DE SAINT-GERMAIN (*L'Union Médicale*), in an interesting lecture at the Hospital for Sick Children, in Paris, of which the following is a short abstract, said:

Obesity is a disease of the cellulo-adipose tissue. It is characterized by a morbid accumulation of fat on those points of the animal economy where it is normally deposited. The cellular tissue under the skin, which gives a comely roundness to the form, and that condition of plumpness so generally admired, may, in becoming infiltrated with much fat, engender the characteristic deformity of certain obese individuals. Phenomena of compression from without inwards are then developed in certain regions, and are added to other troubles produced by internal fat, so as to bring on serious disease; it is in this way that pressure on the pneumogastric nerves in the neck and in the mediastinum produces, at the same time, obstruction of the lungs, palpitation of the heart, and dyspepsia. At the same time, the hypertrophy of the intrapericardiac or cardiac adipose parts brings on fatty overloading of the heart and asystolism. Nevertheless, according to Robin, the circulatory area becomes increased to suffice for the nutrition of the excess of adipose tissue, and there is multiplication, or at least elongation of the capillaries. The demand for red corpuscles increases when the blood-forming function is attacked in all its factors at once; anæmia with deficiency of red corpuscles ensues. The abdominal viscera are twisted or compressed by the omentum and the mesentery, their invasion by fat being the starting-point for the obese belly. They easily become congested. Finally, the too little recognized increase of fat in the track of the artery of the vas deferens and the veins of the spermatic cord may, Dr. de Saint-Germain believes, play an important part in the production of the well-known sexual apathy of obese persons. It is a certain fact, that the fat which accumulates on the sides of the umbilical ring has some

share in the production of umbilical hernia, which is a very serious disease in obese persons, especially when it is strangulated, which only too frequently occurs.

In fifty necropsies out of the fifty-seven, serious cardiac lesion was found; hypertrophy without dilatation in sixteen cases; hypertrophy with dilatation in eight instances; dilatation alone twenty-six times; atrophy alone eleven times. In sixteen cases fatty overloading of the heart was found.

M. de Saint-Germain finds that one predominant question in the etiology of obesity, is to determine whether it is *hereditary*, and he believes that such is the case. (It is sometimes congenital, and may cause dystocia.) Women are more subject to obesity than men.

The best known among efficient causes of obesity are the taking of a large quantity of food, insufficient exercise, and consequently insufficient elimination, the taking of too large quantities of wine and other alcoholic liquors, especially beer, and too much sleep. Dr. de Saint-Germain points out some less generally recognized causes of obesity; convalescence from severe attacks of fever, the too great prolongation of the menstrual flux, and lengthened mercurial treatment.

Boerhaave has recorded a case of obesity which promptly showed itself after copious venesection. It would seem that after violent depression of the organism by privation, cold, fatigue, there is danger of obesity, as a result of the repair of unusual tissue-waste itself, which seconded by an appropriate alimentation may exceed the desired object. The deprivation of limb or castration predisposes to obesity.

To combat obesity M. de Saint-Germain recommends principally and chiefly *proper regimen* and exercise. In children

especially when obesity is concomitant with infantile paralysis, the treatment should be residence in the country at a high and perfectly dry level, near woods, with strengthening baths, shampooing and stimulating saline baths.—*Ibid.*

DISEASES OF THE NERVOUS SYSTEM.

Nervousness Resulting from Intemperance.

We have found Celerina exceedingly valuable in the treatment of nervous exhaustion and other associated ailments of women. In the cases to which we now desire to call attention, where the Celerina is of inestimable value, are those suffering from nervousness resulting from intemperance. Every practitioner of medicine meets with such cases. Men, and sometimes women, come to us trembling and apparently exhausted, all from the effects of intemperance. Such cases are approaching delirium tremens. Celerina is the most appropriate prescription we can give them. A few doses of bromide of potassium may be given, alternated with the Celerina, at first; but after this, for permanent effects, we depend upon the Celerina.—*Am. Med. Jour.*

The Therapeutical Uses of Ergot in Nervous Diseases.

The now widely extended use of ergot in various nervous disorders make the following clinical notes regarding the drug of considerable interest. They are furnished by Dr. J. G. ROGERS, Superintendent of the Indiana Hospital for the Insane:

In this connection I will note the fact again that it is not alone to the influence of ergot and the bromides on the blood-vessel calibre that the potent effects are due, but that they both peculiarly and not exactly similarly do possess a power

to repress excessive nerve-life to a certain extent. The bromide and ergot combination is used in such cases as do not positively require chloral. In milder types of active mania, ergot alone has seemed to exert a decided curative influence, and a large number of such cases have been solely treated with this agent with satisfactory results.

The experience of the year presented in the clinical records, in which the history of every patient is regularly kept, as explained in my last report, fully endorses the efficacy of ergot as a means of controlling cerebral plethora, whether active or passive. Its action is prompt and can be maintained in the majority of cases indefinitely without detriment. Beyond its special effect on the vasomotor system, which is now generally recognized, there is every reason to believe that it exerts a peculiarly controlling influence over the molecular life of nervous tissue when that life has gone beyond the physiological mean of activity and has become erethetic, excessive and self-destructive—what in another less mysterious tissue would be recognized as inflammatory. Practically it does control mental excitement whenever associated with congestion, whether the subject be anæmic and exhausted, or otherwise. In cases of acute mania it seems to be always more or less applicable, and in the acute exacerbations of chronic mania it is equally so. Having no direct hypnotic effect, however, in those cases when delirium has lasted for many days and nights without ceasing, and the patient must either sleep or die, as is often the case when admitted, it is necessary to assist its action with chloral hydrate. This latter agent of itself in full dose tends to produce a secondary passive fulness of the head, but this effect is obviated by the ergot.—*Med. Record.*

Epilepsy from Menorrhagia.

Dr. WILLIAM A. HAMMOND (*Medical Gazette*, October 1, 1881) claims that epilepsy is rarely caused by menorrhagia, and when epilepsy is associated with menstrual disturbance it has a suppression of the function or a diminished flow as its cause. Not infrequently epilepsy which has existed from early childhood ceases when the menses make their appearance.—*Chic. Med. Review.*

Sciatic Nerve-Stretching in Epilepsy.

Dr. PANAS (*Journal de Médecine et de Chirurgie*, January, 1882) has recently reported a case of sciatic nerve-stretching in neuralgia with local epilepsy of the lower extremity, following upon a knife cut which had partially severed the sciatic nerve and produced a neuroma. After the wound had healed, the muscles of the leg and foot remained paralysed and deprived of sensibility. Several months after, the limb became the seat of violent neuralgic pain and convulsive attacks. In spite of all treatment the pain persisted and the patient demanded amputation of the affected limb. The operation of nerve-stretching in lieu of this was performed with Listerian precautions, and was successful.—*Chic. Med. Review.*

Case of Epilepsy Produced by Reflex Irritation.

The following is from the *St. Louis Courier of Medicine*: W. S., a boy aged eleven years, had been suffering from epileptic attacks for several years, which came on at different periods. The boy was rather emaciated, and of very nervous temperament. On examining the boy's penis, it was found that he had phimosis, with a very small preputial opening. He said that sometimes, when

urinating, the prepuce swelled up by the urine which collected, and could not empty as fast as it came from the urethra, causing him some pain, which, however, he never told his parents. The parents were advised to have the boy circumcised, which would materially help, if not entirely cure, this terrible disease of their son. They consented. The next day the operation was performed, having the patient under the influence of chloroform. The wound healed without trouble. From that day his nervousness grew less and less; he has had no other attacks; to-day, one year and a half after the operation, he is stout and fleshy.

Treatment of Hiccough.

As a general rule, the various antispasmodics (*le Medecin Praticien*) have been put in use in obstinate hiccough; the extracts of hyoscyamus and belladonna, valerianate of zinc, etc. The following prescription, due to Dr. PARK, has very frequently given good results:

℞. Potass. bromid., 3 j.; tr. sumbul, 3 ss.; tr. hyoscyami, 3 j.; aquæ camphoræ, 3 j-3 vj. M. Sig.—Tablespoonful every two hours.

M. MARAGE recommends chloroform, as in the following mixture, by spoonfuls every three hours:

℞. Syr. diocod. (Fr. cod.), 30 grams; syr. menth. piper. (Fr. cod.), 12 grams; chloroform, 2 grams; ol. amygd. dulc., 60 grams. M.

GOLA has employed, with success, sulphuric acid, 4 grams in 500 grams of water; Juaritz' infusion of mustard.

Topical applications, acupuncture, rheophores, to neck and diaphragm, etc., should be reserved for very obstinate cases.—*Ibid.*

Hydrocyanate of Iron in the Treatment of Neuralgia.

Dr. J. THOS. STOVALL (*Gaillard's Medical Journal*) calls attention to the value of hydrocyanate of iron in the treatment of neuralgic affections. He regards it as an anodyne, a hypnotic and an analytic tonic, possessing highly sedative properties. He has found it most beneficial in cases of neuralgia dependent upon or connected with an anæmic condition of the system, and in those obstinate cases of neuralgia assuming periodicity. He generally gives it together with quinia and morphia in the following combination:

℞. Quinia, grs. xij.; hydrocyanate of iron, grs. xviii.; morphia, gr. j.; ext. gentian vel. valerian., q.s. M. Make pillular mass; make 12 pills. Sig.—Take one pill every three hours till six are taken, wait six hours and take balance.—*Ibid.*

Tartar Emetic in Chorea.

Dr. MALHERBE, Nante, France (*Journal de Médecine de l'Ouest*), claims that recent experiments with tartar emetic in the treatment of chorea have led him to believe that the use of emetic doses of this substance is of great value in the treatment of the disease. He gives at the same time rather large doses of morphia. Any drug that will make a profound impression on the nervous system is likely to be of value in chorea, but the use of morphia in the diseases of childhood is attended by great risks.—*Chic. Med. Review.*

Tonic in Nervous Exhaustion.

℞. Strychniæ acetat., gr. j.; acid. acetici, ℥ xx.; alcoholis, 3 ij.; aquæ destillatæ, 3 vi.

M. Sig.—Ten drops in water three times a day.

Calabar Bean in Epilepsy.

Every now and then an article appears in some journal about Calabar bean, and it is recommended for various diseases, notably in tetanus and epilepsy. The assistant editor of this journal wrote his graduation essay on Calabar bean, and in studying the literature of the subject found so many cures of epilepsy reported that he was led to believe that we had almost a specific for this terrible disease. Subsequently, during an experience in a large hospital, he was afforded the desired opportunity of using the bean in a very large number of cases of epilepsy, and found it to be utterly worthless. It had no effect whatever, unless it may have intensified the paroxysms, since it was noticed in more than one case that a seizure for which the bean was given was more violent and lasted longer than another attack in the same person when it was not used.—*Med. & Surg. Reporter.*

DISEASES OF CIRCULATORY ORGANS.

Treatment of Heart Disease.

Dr. RENZI has evidently studied with care the actions of three important drugs largely used nowadays in heart disease, viz., bromide of potassium, iodide of potassium, and chloral hydrate; and he has given some important information regarding them. Bromide of potassium is shown to have such a direct influence on the heart and capillaries as to entitle it to a high position among the cardiovascular drugs. According to Prof. Dujardin-Beaumetz, who considers it one of the best heart tonics we possess, the bromide, besides being a nervine sedative, acts directly on the heart, and lessens considerably any irregular action of that organ. He says that, as a nervine sedative, the drug is useful in counter-

acting the sleeplessness which so greatly enfeebls and wears out patients suffering from heart disease, while its value in such cases is greatly enhanced by its direct beneficial action on the diseased organ itself. According to Prof. Sée, bromide of potassium is especially useful in heart affections where we have diminished arterial pressure, rapid and irregular action of the heart, passive congestions, œdema, cyanosis, dyspnœa, and sleeplessness.

Iodide of potassium is shown to be very beneficial in dyspnœa arising from heart disease. It is also of great value in arresting degenerative changes in the heart tissue.

The action of chloral hydrate on the heart is at once to diminish the rapidity of its action, and after a time to reduce its energy. The drug seems to act on the heart by paralyzing either the cardiac ganglia or the vasculo motor centres in the brain. The researches of Claude Bernard, Rokitsansky, and others, would indicate that the latter are chiefly affected by the administration of chloral, for they found that it caused great diminution of blood pressure by dilatation of the capillaries.

In summing up his observations on the three drugs referred to, Prof. Renzi says of bromide of potassium that it lessens the anxiety of patients suffering from heart disease, gives them a certain sense of comfort, and enables them to breathe freely. Under its influence sleep is more easily obtained, is more tranquil, and of longer duration than when induced by other drugs. It is, moreover, a more natural sleep. The bromide reduces undue rapidity of the heart's action and respiration. Cough, however, seems to be aggravated by the use of bromide of potassium alone.

Of iodide of potassium, it is a most useful drug in diseases of the heart. One

of its chief effects is a complete relief from dyspnœa and all asthmatic symptoms.

Chloral hydrate is not much esteemed by him. It can procure sleep of a kind, but is of no use in relieving the dyspnœa so troublesome in cases of heart disease. It is, moreover, dangerous when given in conjunction with iodide of potassium, the latter drug apparently having the effect of greatly increasing its soporific action.

From Prof. Renzi's summing up, it would seem that a combination of the iodide and bromide of potassium is a most beneficial remedy in cases of heart disease.—*Med. and Surg. Reporter.*

Functional Disturbance of the Heart.

In functional disturbance of the heart, due to *dyspepsia*, HUGO ENGEL, M. D., recommends the following treatment in the application of an emplastrum belladonnæ over the region of the heart to remove pain, a diet of milk and toasted white bread, and give of the following mixture a dessertspoonful, in half a tumblerful of water, three times daily, one hour before each meal:—℞. Sodii bicarbonatis, ʒ ij. ; tincturæ nucis vomicæ, f ʒ ij. ; tincturæ gentian. comp., tincturæ rhei simplic., ʒā f ʒ ij. M.—Sig. Shake well.—*Ibid.*

Epistaxis Cured by a Blister.

Dr. VERNEUIL relates the case of a man whose epistaxis occurred every third day. Sulphate of quinia was given without avail ; ergot was administered, with no better result ; so was digitalis. The patient had been a habitual drinker. The liver was thought perhaps to be "cirrhotic," although no enlargement or tenderness was found in this region. A large fly-blister was applied over the liver, since which time the epistaxis has not returned.—*Canada Med. Record.*

DISEASES OF RESPIRATORY ORGANS.**On the Use of Quebracho in Dyspnœa.**

Dr. ANDREW H. SMITH's report to the Therapeutical Society (*New York Medical Journal and Obstetrical Review*, September, 1881) on the employment of this drug for the relief of dyspnœa, contains some points of interest. Of the thirty-two cases covered by this report, eleven were of spasmodic asthma, with or without emphysema and bronchitis. Of these, in nine cases the dyspnœa was notably relieved. In two cases of asthma, associated with bronchitis, no benefit resulted. One patient with emphysema and bronchitis, without asthma, was relieved. One with bronchitis, with obesity, was not relieved. Two with mitral insufficiency were not relieved. One with mitral stenosis was not relieved. One with hypertrophy, with dilatation, was not relieved. In two cases of cardiac disease (form not stated) the dyspnœa was relieved. In one case of fatty heart there was slight relief. Two patients with dyspnœa depending on Bright's disease, in one of whom pulmonary œdema was noted, were relieved. In one case of aortic aneurism, the dyspnœa was relieved till near the close. In one case of cancer of the lung, dyspnœa was relieved. In one case of tonsillitis, the dyspnœa, partly nervous, was relieved. In two cases of pneumonia it was relieved. One patient with hysterical dyspnœa was relieved. In one case of catarrhal phthisis, second stage, the dyspnœa was relieved. In one case of catarrhal phthisis, third stage, it was not relieved. In one case of intermittent fever, with old pleurisy, the patient being an opium-eater, the dyspnœa was increased.

Thus, of the thirty-two cases of different diseases in which dyspnœa form-

ed a prominent feature, this symptom was relieved to a greater or less extent in twenty-two; not relieved in ten; aggravated in one. Dr. Smith, in explaining the action of quebracho, thinks it acts upon the respiratory centre by blunting the sense of want of air, and thus mitigates the suffering from a deficient supply. The extremely disagreeable taste of the medicine and its tendency to produce nausea, are, however, serious drawbacks to its use by the mouth.—*Med. Rec.*

Ether Hypodermically In Adynamic Pneumonia.

Dr. BARTH, Paris (*Can. Jour. Med. Sciences*), recommends the hypodermic use of ether in all adynamic cases of pneumonia, typhoid fever, puerperal fever, etc. He injects two grammes (3 ss.) *per diem*. Of fourteen cases of adynamic pneumonia under his care, eleven recovered.

Forms of Chronic Pneumonia.

With reference to the results of acute attacks, Prof. CHARCOT, in his "Leçons professées à la Faculté de Médecine," describes three distinct forms of chronic pneumonia, which may succeed to acute inflammatory affections of the bronchi and of the pulmonary parenchyma, and are often confounded. The first form represents the chronic stage of acute pneumonia, having its principal seat and origin in the alveoli. He termed this chronic lobar pneumonia. The second and third forms are chronic bronchopneumonia, and chronic pleurogenic pneumonia, succeeding to inflammation of the bronchial tubes, or of the pleura respectively. These divisions are based on the primary seat and nature of the general lesion, all partial chronic pneumonias—such, for example, as are met with around tubercular deposits in the

lung, being excluded.—*Med. and Surg. Reporter.*

Contagious Pneumonia.

Dr. R. JELLEY, writing to the London *Lancet*, details two cases in which pneumonia seemed to be contagious. He inclines to the belief that there is a contagious form of pneumonia, though he believes it to be very rare. The first case was that of a farmer, aged forty-five. He died of pneumonia. The day before his death, his wife, who had nursed him, was taken with the disease, and she also died. Her sister was confined to bed for one day with bronchitis.

The second case also occurred in a farmer, who died. His sister, who had been in frequent attendance on him, was taken with pneumonia the day her brother died, but she recovered. All these cases were seen by a consulting physician, as well as by Dr. Jelley, so that there cannot be much doubt about the correctness of the diagnosis. A careful examination failed to disclose any cause for the second case, in each instance, other than contagion.—*Ibid.*

Iodine in Croupous Pneumonia.

SCHWARTZ (*Deutsche Med. Wochen. ; London Med. Record*) believes iodine to be a specific in croupous pneumonia. If given during the first twenty-four or thirty-six hours from the onset of the initial rigor, it will arrest the further progress of the disease. Ten cases are recorded in which, under this remedy, the crisis occurred before the end of the second stage, and in one case at the end of the first day. The following are the formulæ adopted by Schwartz :

Tinct. iodine, gtt. v.;—0.33 fl. gm.; water, ℥ iv.—120.00 fl. gm.

One tablespoonful hourly.

Iodide of potassium, gr. xxij.—45 gm.; simple syrup, fl. ℥ j—30.00 fl. gm.; water, fl. ℥ iv.—120.00 fl. gm.

One tablespoonful hourly.—*Louisville Med. News.*

Carbonate of Ammonia in Large Doses in the Suffocating Stages of Pulmonary Diseases.

Dr. B. J. RIGGS (*Monthly Rev. of Med. and Pharmacy*):

In the suffocative stages of bronchitis of the smaller bronchial tubes (capillary bronchitis) and of pneumonia we possess no more efficient remedial agent than carbonate of ammonia given in large doses and at short intervals. It is especially useful in these pulmonary complications of the exanthemata.

I gave a child, six months old, cyanosed from capillary bronchitis, two grains of ammonia carbonate, dissolved in water, every two hours, the hot mustard foot-bath every two hours, and repeated mustard plasters to the chest. In order to give an infant of this tender age two grains of carbonate of ammonia every two hours, I have found it best to give it in this way: order a solution of two grains to the drachm, put one teaspoonful of this in a wineglass containing three teaspoonfuls of water and give one teaspoonful of this every thirty minutes, then you get two grains every two hours. It is hardly ever necessary to give it longer than twenty-four to thirty-six hours.

In the congestive stages, if acute bronchitis and pneumonia of adults, the remedy acts equally well. The average dose for the adult is twenty grains, dissolved in water and taken every two hours. Carbonate of ammonia in three large doses acts as a heart stimulant, increasing the *vis a tergo*, it acts on the bowels and kidneys and produces a flow of perspiration. There are some objec-

tions to the use of the medicine in these large doses. In many infants, even diluted as above, it produces stomatitis—the inside of the lips and cheeks become inflamed. This does not, however, supervene in less than twelve or fourteen hours, nor does it occur at all in some infants, and it soon passes away on discontinuing the remedy, which you may now safely do, and use some mild astringent mouth wash or powder. Again, in giving it, it will be necessary to use a silver spoon, as the common cheap spoons we meet with seem to contain an alloy of copper, which on coming in contact with the ammonia, changes the solution to a blue color, and becomes very irritating to the stomach from the resulting raw compound of ammoniated copper (cuprum ammoniatum). Again, thirty grains is laid down as the emetic dose of carbonate of ammonia; twenty grains act thus in some adults, and in some very irritable stomachs. It produces vomiting and persistent hiccough, in these cases, and we have to give it in smaller doses, or discontinue it altogether. In some cases it purges too freely in these large doses; the patient weakens from the constant purgation. When it has either of these disturbing effects it is best to discontinue it, and use such other medicine as your judgment dictates. It much more rarely disagrees with infants and children than with adults, and it is in this class of sufferers that it is used most satisfactorily.

The best way to give the drug is dissolved in water, without any syrup or other addition.

It is not only valuable in the suffocative stage of bronchitis and pneumonia, but also in asthma and pulmonary oedema, from any cause, where there are evidences of a failure of heart power where it is necessary to render this organ

prompt and efficient support.—*Canada Med. Record.*

Treatment of Hay-Fever.

Dr. HERMANN HAGER, who has observed a case of catarrh with subsequent asthmatic trouble and loss of appetite, which closely resembled the hay-fever of England and the United States, employed the following:

℞. Quinidiæ, 3 ijs.—10.00 gm.; tragacanthæ, 3 j.—4.00 gm.; althæa rad., gr. xv.—1.00 gm.; gentian. rad., 3 ij.—8.00 gm.; glycerin. acid. hydrochloric, ʒā ʒl cvij.—7.00 gm.

Make two hundred pills. Take three every two hours.

Treatment of Consumption.

Dr. ROBERT SAUNDBY (*Practitioner*) gives a very valuable *résumé* of this subject. Cod-liver oil and quinine are Dr. Saundby's sheet anchors, the hypophosphites having disappointed his expectations. Good nourishment and attention to the digestive functions form the best treatment of cough. If a consumptive patient want to take a short cut to the next world, he has only to take an opiate, paregoric for an example. Codeia is most valuable. Camphor inhaled, a lump under the pillow, or some powder in a jug of boiling water, forms an effectual anodyne. To prevent dryness of the mouth, a compressed tablet of chlorate of potash and borax in the cheek remains all night, and causes sufficient salivary secretion to keep the air-passages moist. The bronchitic attacks are to be met by the use of turpentine vapour and counter-irritation, and sulphur internally. Nothing controls the profuse secretion of the bronchial mucous membrane so readily as fifteen to twenty grains of sulphate of iron, given in pills or mixture during the day. The

use of oro-nasal inhalers, charged with carbolic acid or eucalyptus oil, is strongly advocated. For anorexia, quinine does more than any other drug; while the peptones, Hoff's malt extract, and such like preparations, are, in many cases, most valuable. Cod-liver oil, in doses of one teaspoonful, after meals, thrice a day, Dr. Saundby believes to be quite sufficient, larger doses not being assimilated. The diarrhœa is always controlled by two drachms of dilute sulphuric acid to the pint of sugared orange-water, drunk *ad libitum*, unless ulceration be present; and then starch and laudanum enemata, or an enema of half an ounce of liquid extract of ergot, will, in most cases, give relief. The sweating is generally controlled by the same means as are used for the diarrhœa; but if not, then atropine or picROTOXINE must be used. Hæmoptysis Dr. Saundby treats with ergot internally or subcutaneously. In conclusion, a tabulated view is given of the different remedies. Specific: quinine, cod-liver oil; Cough: liquorice, camphor, codeia lozenges; Bronchitis: turpeatine inhalations and epithems; Purulent expectoration: eucalyptus inhalation, sulphate of iron; Anorexia: quinine, peptonized food malt extracts, cod-liver oil, ether, alcohol; Diarrhœa: sulphuric acid, ergot, ergotine. A good prescription in many cases is the following: R. Quiniæ sulphatis, gr. j.; specific, tonic; Ferri sulphatis, gr. v.; for profuse expectoration; Acidi sulphuric diluti., ℥xv.; for sweating, diarrhœa, and hæmoptysis; Aquæ, ad ʒj. M. To be taken thrice daily. If the sweating be not hereby checked, a minim of solution of sulphate of atropine may be added, and codeia lozenges may be given, with cod-liver oil in addition, if need be.—*London Medical Record—Can. Journal Med Sciences.*

MISCELLANEOUS.

Substances for the Preservation of Dead Bodies for Dissection.

BY A. H. P. LEUF, M.D., BROOKLYN, N. Y.

"Bacteria produce, through the chemical changes of which they are the direct cause, the most effective substances that can be used to destroy them." Hence, "the germs of disease finally produce their own destruction by the operation of their growth and development." (*A. Wernich*). It is claimed (by *Naegeli*) that lower organisms cannot be destroyed without the aid of heat, and that heat is not always equally effective. Moist heat, however, is more effective than when dry. But even a boiling heat will not always destroy bacteria if the fluid be neutral. The more acid the fluid the more effective will it be, even though the heat be diminished. Different species of bacteria are differently affected by the same degree of heat. The spores or germs are not as easily destroyed as the parent organisms. The most favorable substances for the increase of bacteria are the nitrogenous, and of these the albuminoids. Of the non-nitrogenous, sugar stands first, while K., P., Mg. and S. are the most favorable of mineral substances.

Of the substances fatal to low organic life the following are some of the most effective. Concentrated mineral acids, the chlorides of mercury, sodium, zinc, the sulphates of copper and zinc, benzoic acid and its salts, carbolic acid, salicylic acid, aromatics, alcohol, chloral hydrate, iodine, bromine, chlorine, sulphur, etc.

All of these are not applicable for dissecting purposes. Saltpeter is an excellent preservative of color. So is chloral hydrate. If it is desirable to preserve the color of muscles *always* add saltpeter to the preservative mixture.

The following are good solutions for injecting bodies :

No. 1, carbolic acid, 20 ; saltpeter, 20; glycerine, 200; water, 800. The objection to carbolic acid is that too much must be used. It bleaches the muscles, hence more saltpeter is needed. Too much of the latter modifies the bodily textures. The following are good substitutes for the carbolic acid in No. 1: The following substances will effectually replace the carbolic acid of No. 1 fluid in the proportions expressed : (No. 2) Phenylacetic acid, 2.5 (sat. sol.); (No. 3) Scatol, 0.5; (No. 4.) Hydrocyanic acid, 0.8; (No. 5.) Indol, 1.1 (sat. sol.); (No. 6.) Kresol, 5.0; (No. 7.) A 10 per cent. solution of zinc chloride is very good, but it bleaches. If this is objectionable add saltpeter. Use about twelve liters by hydrostatic pressure for several hours. (No. 8.) Eight liters of *warm* water, arsenite of soda, the size of a duck's egg. Inject, while warm, a sufficient quantity to wash all the blood out of the vessels. This is known by the fluid appearing clear from the internal jugular vein. If saltpeter be added to this solution, I believe it to be the best for ordinary dissecting-room use. I believe it acts on the dissector as a tonic, for these reasons: (1.) It prevents decomposition of the bodily tissues of the subject. (2.) The fat of the subject is prevented from becoming rancid or deleterious. (3.) Both fat and arsenic are absorbed through the manual integuments and thus act in the way stated. This is not purely hypothetical. I have noticed it on myself by far too many times to be a mere coincidence. And again, I have noticed it more extensively on others. Give it a fair trial and observe its results. (No. 9.) Two injections of a saturated solution of sodium chloride, with saltpeter. (No. 10.) Alum, 100; chlorate of sodium, 25; nitrate of

potassium, 12; carbonate of potassium, 60; arsenic acid, 10; water, 1,000; molasses, 4. When this solution has cooled and been filtered, add to 10 liters of the fluid 4 liters of glycerine and 1 liter of methylic alcohol. Use from two to five liters for an injection. (No. 11.) Salicylic acid, 4 grammes; saltpeter, 4 grammes; water, 1 liter. (No. 12.) An 80 per cent. solution of vinegar, containing 10 per cent. of saltpeter, would make a good preserving fluid. (No. 13.) Warm water, 20 liters; alum, 0.4 kilogramme; sodium chloride, 0.4 kilogramme; saltpeter, 0.4 kilogramme; bichloride of mercury, 5 grammes. This is an excellent preservative fluid, and does very nicely for boneless tissues. This is Godby's fluid *modified*. (No. 14.) A saturated solution of chloride of lead is a good preservative. It is prepared as follows: Add 2 grammes of lead-nitrate to 0.5 liter of water. Dissolve 8 grammes of sodium chloride in 8 liters of water. Mix the two fluids and the chloride of lead is formed, part of which precipitates. The clear, supernatant fluid, is to be used in the usual manner.

Subjects injected with paint have a more or less pleasant odor when compared with that of those injected with plaster. This is due to the turpentine contained in the paint. This substance aids materially in preserving a body; hence the reason for subjects keeping better if injected with paint than those that contain plaster. Turpentine diluted with water would, I believe, make one of the surest and pleasantest preservative solutions. If the color of the muscles is to be preserved, don't forget the nitrate of potash.

MEDICINE.

CONSTITUTIONAL DISEASES.

Treatment of Typhoid Fever.

Prof. DAVIS, M. D. (*Chic. Med. Jour. & Examiner*), while appreciating fully the value of frequent sponging of the cutaneous surface with water, whenever it is hot and dry, as a palliative in typhoid fever, I have found it to exert but a feeble influence over the progress of those general deteriorate molecular changes throughout both the organized structures and the organic constituent of the blood, which constitute the essential pathology of this variety of fever. To more effectually counteract these morbid changes we need some remedy capable of exerting a general alterant and antiseptic influence, and maintaining it for considerable time without depressing the strength, or creating local complications. The last time I took you to the bedside of typhoid patients I called your attention to the effects of iodine, which I had then commenced giving with the hope that it might be found capable of exerting more nearly the actual alterant and antiseptic influence needed, than any of the remedies hitherto used in such cases. Since then I have continued to use the remedy in all well marked cases of typhoid coming under my supervision, both in the hospital and in private practice. Without counting the case before us to-day, which is yet under treatment, the whole number of well marked cases in which the iodine was given as the leading remedy, is fourteen. Seven of these cases occurred in private practice, and the other seven were treated in these wards. Of the seven cases treated outside the

hospital, five came under care during the first three days after the patients took to their beds; the other two not until the first half of the second week. Of those treated in the hospital, two were admitted on the third day of the fever, two on the fifth and sixth days, and the remaining three between the seventh and tenth after the commencement of the disease. You will note that nine of the fourteen cases were brought under treatment during the first week after the onset of the disease, and the other five not until the first half of the second week. The treatment in all these cases consisted in the administration of from 12 to 15 minims of the following solution of iodine:

R. Iodinii 0.5 grams—grs. viij.; potassii iodidi 2.0 grams—grs. xxx.; aquæ distillatæ 45.0 cc.— $\frac{3}{4}$ jss. M.

These doses were generally diluted with 30 cc. or two tablespoonfuls of sweetened water, and repeated every four hours for the first three or four days, and then every six hours until indications of convalescence appeared. Whenever the intestinal evacuations become too frequent and thin, a teaspoonful of the ordinary turpentine and laudanum emulsion was given between the doses of iodine. When the temperature rose to 40 C. (104 deg. F.), and the skin dry, the patients were frequently sponged with cold water. Two of the seven treated in private practice took two grains of sulphate of quinia three times a day during the last week of their progress. Nearly all of the seven treated in the hospital wards took small quantities of the mineral acids, largely diluted with water, during the earlier part of their treatment,

and small doses of quinine three or four times in the twenty-four hours during the latter part. All the fourteen were carefully nourished by the faithful giving of milk, wheat flour and milk gruel and beef-tea, at regular intervals.

No alcoholic liquids, either fermented or distilled, were given to any of these patients during any part of their treatment. Of the nine cases in which the treatment was commenced during the first week after the patients took to their beds, four convalesced between the twelfth and fourteenth days; three between the fourteenth and seventeenth, and two between the seventeenth and nineteenth. Of the five cases in which the treatment was not commenced until the first half of the second week of their progress, three convalesced between the eighteenth and twenty-first days, and the other two between the twenty-first and the twenty-fifth days. No one of the fourteen suffered a relapse, and no case terminated fatally. I now call your attention to the fifteenth case, in room 11, which was admitted into the hospital on the 3d of December, presenting all the symptoms of a severe grade of typhoid fever, which had commenced three days before his admission. He was put directly on the use of the solution of iodine, alternated with the turpentine and laudanum emulsion, to control a loose and tympanitic state of his bowels, with milk, and milk and flour gruel for nourishment. The case progressed favorably, and convalescence was established in about twenty days from the commencement of the disease, or seventeen days from the beginning of his treatment. This convalescence proceeded until he was able to be up, dressed and about the house, with a good appetite and natural state of his evacuations. Nearly two weeks from the commencement of his convalescence, he began

again to complain of the premonitory symptoms of fever, and on the third day had so distinct a chill that it was thought that he might be under the influence of malaria, and he took three decigrams (grs. v.) of quinine three times a day for two or three days. The fever, however, again assumed an unmistakable typhoid character, with considerable delirium and some looseness of the bowels. The original treatment with iodine and the emulsion was resumed, and has been continued to the present time. His temperature has declined below 38 deg. C. (99 deg. F.) in the morning, and 38.3 deg. C. (101 deg. F.) in the evening, with a clean, moist tongue, and other indications of approaching convalescence. I learn that this patient has formerly been affected with insanity, and his brain and nervous structures may have been somewhat enfeebled.

To prevent being misunderstood, I will add, that I am not using iodine as a *specific* curative agent in typhoid fever, but simply as a general alterant and antiseptic, adapted to fulfil certain rational indications afforded by the pathology of the disease, and always to be aided by such collateral remedies as the abdominal and other local symptoms may indicate.

From my present experience, I am led to think it is a remedy of great value, especially when its use is commenced in the forming stage, or during the first week after the confinement of the patient from the development of the fever.

Iodide of Potassium in Typhoid Fever.

Dr. OATMAN claims that iodide of potassium is as much a specific in typhoid as quinia is in intermittent fever. He says: An adult with uncomplicated typhoid may take five grains of iodide of potassium every three hours in sweet-

ened water. Also every three hours give one dessertspoonful of the following:

R. Ol. terebinth. tr. anisi āā, 1 fl. 3; vitelli ovi., No. 2, Sacchari, 2 3; Aquæ puræ ad., 3; Ft. emulsio.

M. Sig.—This emulsion may be taken between the doses of the iodide. —*Pacific Med. & Surg. Jour.*

Administration of Turpentine in Typhoid Fever.

Turpentine, which is often of value in typhoid and other adynamic fevers, is a very difficult remedy to administer. Stokes (Lectures on Fever) used to administer it in combination with egg-nogg. The *Courrier Médical* proposes the following formula which, it claims, destroys the taste and odor: Essence of turpentine, two drachms; sulphuric ether, forty-five minims; these should be thoroughly mixed, after which an ounce of orange flower syrup and four ounces of water are to be added. Of this mixture a dessertspoonful should be given every two hours, or according to the indications.—*Chic. Med. Review.*

Treatment of Malarial Fever.

DR. HICKMAN (*Med. and Surg. Reporter*):

No case of malarial fever, however grave, should terminate fatally. The mistake most commonly made is to purge the patient. I feel justified, by experience, in laying down the statement that a malarial fever patient should never, under any circumstances, be actively purged. The best results are obtained by letting the bowels entirely alone, save under a circumstance to be mentioned below. I need scarcely state at this day, that the one remedy to be relied upon is one or other of the salts of cinchona. But above all, allow me to impress the fact that no conservatism

should be practiced here. Whichever of the salts of cinchona you use, use it unsparingly and with a fearless hand. If you use sulphate of quinia, give it in from twenty to thirty grain doses, repeated from three to four times in the twenty-four hours. If it is vomited, at once repeat the dose, or administer it hypodermically, or by the rectum. I have learned by the frequent abscesses consequent upon the hypodermic method, to greatly prefer the rectal injections. If the remedy does not seem to be taking proper effect, a one-grain dose of calomel will greatly favor its absorption from the stomach. Quinia so given has a vastly better effect than even the same quantity in divided doses. This can only be a question with those who have had no experience with the treatment with large doses. Now as to the diet and treatment of prominent symptoms. The patient will crave nothing; nothing tastes natural to him and, as a rule, the best way is to urge no food while the fever rages in intensity. After this, and during convalescence, allow him anything he may crave and feed him well, beginning with an easily digested aliment. The nausea in most cases will be intense, and it is well to attempt relief, though you may try everything and be utterly foiled. Sometimes small doses of calomel (from one-twelfth to one-sixth grain), as recommended by Bartholow, will relieve. Warm water will in some cases produce the desired effect. I mention these two plans because they are most effective, as a rule. The patient will experience great comfort and benefit from bathing or rather sponging with tepid water, to which may be added a little bay rum. This may be repeated from two to five or six times a day. He should be allowed a moderate amount of liquid, yet not as much as he sometimes craves; in general, the

better plan will be to allow him to suck a moderate amount of ice. Stimulants should not be given early, but upon the yielding of the malady will be found of advantage. It is occasionally necessary to control the sweating of beginning convalescence, and in no way can this be done better than by a one-quarter grain of the extract of belladonna once or twice daily. Of course the sweating should not be interfered with unless the condition or comfort of the patient demand it. The medicines which the writer has been in the habit of using during convalescence are either the ferated elixir of cinchona or Aitkin's syrup of the phosphate of iron, quinia and strychnine.

Iodine in the Treatment of Malaria.

Dr. MORRISON, in an article in the *Maryland Med. Journal*, on the above subject, states that the tincture of iodine, in doses of fifteen minims three times a day, equals, if it does not surpass, cinchonidia in its action in acute malaria. It was tried in 250 cases at the Baltimore Dispensary during the year 1881, and was found more successful in effecting a cure than the usual malarial mixture of cinchonidia and arsenic. The *rationale* of its action is, that iodine destroys the organisms in the blood which cause the symptoms of malaria, or in other words, destroys the malarial poison.—*Canada Med. Lancet*.

Malaria and Diabetes.

At a recent meeting of the Académie, M. VERNEUIL called attention to the relations existing between glycosuria and malarial diseases. Both maladies coexisted in six cases observed in his service, where the patients entered for various surgical diseases (epithelioma of the penis, gangrenous patch (plaque) on the heel, tumor, etc).

The principal memoir on the coexistence of these two morbid states is by M. Burdel, of Vierzon, presented to the Acad. des Sciences, in 1859. This observer found sugar in 80 out of 86 cases of true intermittent fever. The conclusions he arrives at are as follows:

1. There exists in malarial fever a veritable glycosuria.

2. This diabetes is ephemeral; it appears with the fever, persists during its continuance and disappears with it.

3. The glycosuria of intermittent fever reveals the deep and special effect this form of fever has on the equilibrium existing between the cerebro-spinal and the sympathetic nervous systems.

4. This explanation, given by Cl. Bernard, is in conformity with the clinical facts.

5. The more violent and intense the access of fever, the greater the quantity of sugar found in the urine.

6. When, on the contrary, the attacks become more numerous and less intense; when, in a word, the malarial cachexia becomes established, then it will be found that the quantity of sugar is much less considerable.

The cases observed by M. Verneuil have led him to somewhat different conclusions, and none of his patients had had actual attacks of intermittent for some time previous to coming under his observation. These cases and others have led M. Verneuil to arrive at the following conclusions:

1. Malaria frequently engenders glycosuria.

2. Which presents itself in two forms: the one cotemporary with the febrile attack, and like it, short and fugacious; the other supervening at a period, more or less distant, independent of the febrile paroxysm and permanent.

3. Permanent glycosuria seems to attack, by preference, vigorous subjects,

having some leaning to the arthritic diathesis.

4. Glycosuria, of malaria origin, appears to be one of the benign forms of diabetes.

5. Intermittent affections supervening in such subjects, may take on certain characters of malaria or glycosuria, or of both diseases at the same time.

Traumatic lesions may awaken or aggravate the two diatheses, particularly the accidents of malarial origin.

Carbolic Acid in Facial Erysipelas.

Dr. ROTHE observes (*Betz. Memorabilien*) that, however efficacious the subcutaneous injection of carbolic acid proves in arresting the course of erysipelas, it is not suitable when the face is the part attacked, for not only does it give rise to considerable pain, but induces a swollen and painful condition of the periphery. For some years past he has been in the habit of using the following application:—Acid. carbolic., sp. vini., āā, one part, ol. terebinth. two parts, tinct. iod., one part, glycerin, five parts; pencilling the inflamed skin and its vicinity with it every two hours. No pain or sense of burning is produced, and the skin is usually next day pale and wrinkled. The further progress of the disease is more effectually arrested than by any other remedy, any new patches being rapidly effaced, so that in three or four days the facial erysipelas is usually at an end. The pencilled places should be covered by a very thin layer of wadding. When febrile action is present the ordinary internal measures must also be resorted to.—*Canada Lancet*.

Milk-Sickness.

Dr. JOSEPH SPAULDING (*Western Medical Reporter*). The disease has been called "trembles," "tires," "slows,"

"puking fever," etc. It seems to be peculiar to the great central valleys of the Ohio and Mississippi Rivers. It may, however, be transmitted to persons living at quite long distances from its place of origin, by the butter, milk, and beef of affected animals.

In my opinion the cause is a plant containing a fermentive poison. This plant is distasteful to animals, and only eaten when there is a scarcity of vegetable food. A friend described it as a low vine running underground, and occasionally sending up a stem with leaves.

Symptoms.—Mild cases: they are languid, nauseated, slow pulse, dry, red tongue, cannot eat. Medium severe cases: nauseated, bad breath, dimness of vision, muscular soreness, a general lassitude, perhaps muscular trembling, an entire distaste for food, no fever, pulse slow, surface cool, and feels to the touch waxy. Severe cases: constant retching, very little thrown up; odor of breath and excretions exceedingly disagreeable; you can hardly stay near them or even in the room; the stench is so pungent, offensive, you will want a draft of fresh air in order to sit by them a sufficient time to make your examination; the bowels are very constipated, so much so that you will let your patient die if you fail in your diagnosis; pulse weak, surface cold and dry, eyes sunken, the salivary glands cease to act, the mouth is dry and red; the fauces are also dry; the passage of the air in respiration sounds as if forced through dry parchment; the gastric mucus becomes less and less, and shortly none is secreted. The liver at first secretes bile, but later no bile is secreted, and to appearance glandular action is entirely suspended, even the bronchial mucus. A very noticeable feature is the peculiar odor. Treatment is to stimulate early and late, give cathartics in some way;

antiseptics if possible, as creosote, whiskey in large amounts, from a pint to a quart a day. It acts here almost as in cases of snake poisoning.—*Med. Record.*

Antiseptic Medication.

Dr. J. F. CORRIGAN (*Med. Record*): Many of my professional brethren have lately given attention to the system of antiseptic medication introduced by Dr. Déclat, of Paris. The successful results of this system in Europe, and more especially in France and the French colonies, where it is better known, have already been sufficiently extended and marked to justly claim the examination of our American *confrères*.

Modern scientific investigations have tended, with increasing force, to prove that diseases are caused by the introduction into the system of minute germs, which, finding themselves in a fluid—the blood—suitable to their development, rapidly increase in strength and numbers.

It is known, from the experiments of Dr. Calvert, that a solution of the salts of mercury prevents all animal fermentation; that a solution of the salts of quinine prevents all vegetable fermentation, and finally, that a solution of carbolic or phenic acid prevents both. The salts of quinine, however, though readily soluble in the acids of the stomach, begin to lose their virtues the moment they are introduced into the alkaline blood, and consequently do not meet the requirements of an efficient germicide.

It is evident that, in zymotic diseases, the sooner the ferment-destroying substances are administered in full doses, the sooner will be arrested the propagation of the germs, and the better protection afforded to the integrity of the globules. It must not be forgotten that these germs develop in proportion to

the lower degree of vitality of the blood.

Phenic acid is the basis and most important constituent of all the remedies introduced by Dr. Déclat. The term phenic is here used instead of the more usual one of carbolic acid, because it is the term employed by Dr. Déclat in his numerous works, and to distinguish it from the carbolic treatment of Lister, which originated several years later, and is different from the former in many important elements.

Previous to the year 1861, carbolic or phenic acid had not been made available as a medicine, properly speaking, that is to say, as a remedy against disease, particularly of the internal organs. This was due mainly to its impurity, even of the best specimens ordinarily sold. It can, however, be obtained in a chemically pure state by processes given by Dr. Déclat. After describing the process of extracting the acid from bituminous coal, he adds: "The phenic acid is then rectified by distillation after treating it with five per cent. of caustic potash. At first a mixture of water and acid passes over, then the acid alone in a state of comparative purity. A second, and, if necessary, a third distillation purifies it completely. It then sublimes in handsome, rhomboidal, silky needles."

The pure acid crystallizes always in long, needle-shaped crystals, never in masses. It has no action on litmus paper. It is soluble in distilled water, in the proportion of six per cent. A specimen which does not respond to these tests is not chemically pure. In its pure state it changes readily on exposure to moisture, air and light. This change can be prevented by combining it, atom for atom, with syrup or glycerine.

When taken internally in either of these combinations, it resumes its nascent condition so soon as the processes of

digestion and absorption free it from its combination. Being then readily diffusible, it permeates the system, performing its germicidal work on the way, and passes off principally by the lungs and skin, but a slight amount being eliminated by the kidneys.

In addition to its principal effect as a germicide, there are two minor effects that claim attention. One is that it has a tendency to cause constipation. The second is that, to a very slight degree, it diminishes the fluidity of the blood. In many cases, especially those of chronic diseases, these effects may not be objectionable.

In all acute diseases, however, from simple bronchitis to yellow fever, there is a rise of temperature depending on a fermentative action more or less extended, and corresponding alteration in the blood. This change shows itself most markedly by a diminished fluidity of the blood, tending toward congestion of various organs, especially of the brain and lungs.

To counteract this result of febrile action and the similar tendency of phenic acid, it is necessary to add to the latter some agent which facilitates the circulation by keeping the blood fluid, and at the same time stimulates the nervous system. Ammonia, in its chemically pure and gaseous state, meets these requirements, and should therefore be associated with the phenic acid, making an ammoniacal phenic acid. It can be made by passing a current of ammoniacal gas, very dry, upon rectified, pure, and very white phenic acid contained in any vessel. The operation is continued until saturation. The matter is made sufficiently hot in order to liquefy the mass, and the liquefaction may be accelerated, if that is necessary, by heating the vessel during the passage of the current of gas.

In chronic diseases, the germs may remain a long time in a latent state, awaiting conditions favorable to their development. This is the case both with hereditary diseases, as tuberculosis, and with acquired maladies, as rheumatism, diseases of the skin, lupus, etc. It has been found by experience that the addition of sulphur to phenic acid is useful in many of these diseases. This combination can be made as follows: After the first preparation above alluded to is made, that is to say, after the phenic acid is completely saturated with ammoniacal gas, let a current of sulphydric acid penetrate into this preparation, the said acid being equally dry, and with the exclusion of the air. This produces an ammoniacal sulpho-phenic acid.

The proper dose of absolutely pure phenic acid for internal use, in an adult, is twenty-five to fifty centigrammes, about four to eight grains daily, to be increased as needed to one or two grammes, about fifteen to thirty grains a day. This gives doses of from two to ten tablespoonfuls a day, of the syrup or glycerine combination as generally used. They may be taken pure or mixed with water, and preferably half an hour before or some hours after a meal. The doses for children are proportionately smaller, as in general medication.

In zymotic diseases, in those terrible emergencies which arise sometimes from poisoning by animals, from dissection wounds, in congestive chills and in similar dangers, the most direct and logical course of arresting the fermentative process is by the immediate introduction into the circulation of an efficient antiseptic liquid.

After numerous experiments upon animals and also on his own person, he ascertained that the subcutaneous cellular tissue would easily admit, in favorable parts of the body, as many as a hundred

drops of a solution containing two per cent. (two grains) of pure phenic acid.

Two to three injections a day, sometimes only one, will often be followed by more marked results than when fifteen grains have been given by the mouth.

The parts most suitable for hypodermic medication are the inner sides of the arms and thighs, and the front of the chest and abdomen. The latter, however, is the place of election.

To sum up the indications for the employment of phenic acid and its combinations: in slight sickness, in malaria, and in many chronic diseases the preparation of pure phenic acid should be used.

Whenever fever is present, as in zymotic diseases, the combination with ammonia is indicated, either alone or alternately with the simple acid.

The use of the combination with sulphur has already been referred to.

Hypodermic injections of the various preparations should be resorted to where a more rapid and thorough effect is needed, whether in adults or children. In many cases both methods should be used.

For external use the acid may be mixed with glycerine and water, the acid being in the proportion of ten per cent. and applied locally in diseases of the throat, etc. This preparation may be added to enemas, using fifteen to forty-five grains for this purpose, may be mixed with equal parts of oil and well shaken with it, forming a very pleasant and useful application in burns, etc., or may be further diluted with water in the proportion of one part to twenty or fifty of water, and thus employed for gargles, for washing inflamed surfaces, for vaginal injections, etc.

For inhalations, the dry emanations or water solutions in the form of spray should be used, the latter not stronger

than one-half to one per cent. of acid. There seem to be no counter-indications to the use of phenic acid, nor does it interfere with any coincident medication.

Thymol in Diphtheria.

The following mixture, containing thymol, has, we read in *Le Progres Médical*, proven very efficacious in Dr. Warren's hands:

℞. Thymol, gr. ivss.-viss.; pot. chlorat., 3 ijss.; quiniæ bisulph., 3 ss.-3 j.; sp. vini gall., 3 viijss.; glycerinæ, 3 ij.

For children, from two to five years of age, a dessertspoonful may be given every hour, or every second hour. The mixture should be given, if possible, undiluted, in order to obtain its excitant, almost irritant action on the buccal parietes. This mixture may be employed as a prophylactic agent against diphtheria and malaria. By the addition of a few drops of tincture of iron to each dose, it acts as a tonic, and may be employed with success in typhoid fever where diarrhœa is present.—*Med. & Surg. Reporter*.

Local Medication in Diphtheria.

Dr. J. R. JONES (*Detroit Clinic*):

Having used lactic acid, chloral, lime-water, salicylic acid, sulphides, and sulphurous acid, as recommended by their various advocates, as well as the astringent salts of iron, I obtained much the best results with the latter, and the object of this paper is to draw attention to the use of Monsel's solution of the subsulphate of iron as a local remedy in diphtheria.

Dr. J. Lewis Smith, in his latest edition of "Diseases of Children," speaks of it in these words: "In most cases of diphtheritic inflammation of the fauces the spray suffices for local treatment, but the following mixture, applied by a

large camel's hair pencil, is also very effectual, immediately converting the pseudo-membrane into an inert mass, and putting a stop to all movements of the bacteria which swarm in it, as I have repeatedly observed under the microscope :

"R. Acid carbolic, gtt. viij.; liq. ferri. subsulphat, ʒ ij.-iij.; glycerine, ʒ j.—M.

"This may be used two or three times daily, between the spraying, or oftener without the spraying. It is not irritating (such an effect would condemn it), but it is dreaded by most children on account of the unpleasant 'puckering' which it produces."

That it will cut short the local trouble in a large number of cases I am well satisfied; and if care is taken to obtain a pure preparation which will answer to the description given of it in the U. S. Dispensary, there will be no complaint of its causing irritation. On the contrary, patients invariably say they feel better, and one might easily imagine so, from the facility with which they can clear the throat. It coagulates the albumen of the false membrane which it readily penetrates, and exerts a healthful astringent effect on the engorged blood-vessels beneath. One application daily for two or three days, either undiluted or mixed with glycerine, is generally sufficient, and a weak solution of the same, used as a gargle or swallowed, frequently keeps the breath free from the odor of decomposing tissue. Having seen such good results from its use, I am steadfast in my faith, and would urge others to give it a trial. In every case attention was given to the general supportive treatment and the free use of quinine, stimulants, and tincture of chloride of iron, continued throughout, the local medication being auxiliary only.

Treatment of Diphtheria with Ice.

M. DE BLEYNIE affirms that the results he has obtained from this treatment during the past sixteen years permit him to affirm that "diphtheria treated with ice is constantly cured."

The following mode of administration is recommended : (1) Introduce into the mouth of the little patient a small fragment of ice every ten minutes, without any interruption, whether the child is awake or sleeping. Young sleeping children absorb the ice without awakening. The fragment of ice should be swallowed when it is almost melted. (2) Do not cease giving ice until the false membranes have entirely disappeared; this happens from the second to the eighth day. (3) Keep good watch over the throat, and, if the membranes reappear, recommence the treatment, and, in fact, for some days, it will be better to continue giving ice every half hour, lengthening the intervals each day. (4) From the beginning give wine and good nourishing food.

The Treatment of Sea-Sickness.

Dr. MILAN SOULE (*Med. Record*) says : "About three years ago I began to use the bromides in treating seasickness, following, as nearly as possible, the direction given in Dr. Beard's valuable monograph on that subject. I had then been in the service of the Pacific Mail Steamship Company nearly four years, and as my field for experiment was large, I had tried nearly every drug or combination of drugs that had ever been proposed for the cure or alleviation of this disagreeable malady. Repeated failures and humiliating disappointments had so shaken my faith in the power of drugs over this disease, that I began to use the bromides with a good deal of doubt and hesitation. Greatly to my surprise and gratification, however, I

found that I was able to entirely prevent or greatly to alleviate the disease, and have not one single failure to record. The following is the combination I most frequently employed, viz. :

℞. Sodii bromidi, ʒ iv.; ammonii bromidi, ʒ ij.; aquæ menthæ piperitæ, ʒ iij.—M.

Sig.—A teaspoonful before meals and at bedtime; begin treatment three days before going on board.

"When preparatory treatment had been neglected and the disease fully established, I put a teaspoonful of the above in a half-tumbler of water, add a drop of ext. ipecac. fluid, and give a teaspoonful every five minutes; it generally relieves the patient in less than an hour. I have received several letters (guinea enclosed) from passengers, asking me to send them the above formula. Next to the bromides, I have found hyoscyamia the most successful remedy. Atropia will frequently afford relief, but is not altogether safe, as I have noticed a few cases of retention of urine to follow its use. I gave nitrite of amyl a fair trial, but it proved a complete failure. I have notes of several cases where the bromides entirely prevented sea-sickness during voyages of from twenty to thirty days, although these patients were always sick on previous voyages."

DISEASES OF THE URINARY ORGANS.

Treatment of Diabetes Mellitus.

Prof. FLINT, in a clinical lecture on this subject, says that the treatment is emphatically *dietetic*, giving as his opinion that if the withholding from the food as far as possible *sugar* in any form, and all *starchy* constituents of diet capable of being transformed into sugar, fails to improve the patient, other remedies are of little use. Among various

medicines, the use of sulphide of calcium, beginning with one-eighth grain doses three times a day, and gradually increasing the dose, has seemed to be quite beneficial, especially when combined with a strict diet.

Successful Treatment of Diabetes Insipidus with Valerianate of Zinc and Tincture of Valerian.

Dr. R. PRIOR, of Brux, relates a case (*Lancet*) in which a patient suffering from diabetes insipidus was successfully treated with the above remedies. The patient, a man aged sixty-eight, was passing ten pints of water daily, and suffering from the usual accompanying disturbances. He was put upon valerianate of zinc, gr. ij., t.i.d., and tincture valerian co., ʒ jss., t.i.d. This gradually increased to gr. xij. t.i.d., of valerianate, and ʒ ij., t.i.d., of simple tincture. In the course of two months the bad symptoms had entirely disappeared, and six months later he was still well.—*Med. Record*.

Diabetes.

Dr. FRIEDENWALD: A man presented himself for life insurance examination, and all was favorable until the kidneys were examined, when quite an appreciable quantity of sugar was found in the urine. Subsequent examination showed sugar still present. He then said he had felt a little unwell for some days, and was treated by his physician for biliousness; had thirst, and had to get up once in the night to urinate. I gave him carbolic acid, gr. j, four times a day, and he was much improved; he has used it for two weeks, with restricted animal diet, and the sugar has disappeared, whether permanently or not I cannot say. I have used this treatment in two other cases, one of which was cured, and one much relieved.

Dr. LYNCH, Drs. Smith and Bridges use sulphide of calcium in these cases. They give grs. ij., every four hours. It will diminish the quantity of urine excreted, and is, therefore, useful in diabetes insipidus. I think I cured a case about two years ago with this remedy.—*Med. and Surg. Reporter.*

Chloral Hydrate in Diabetes.

The Glasgow *Medical Journal* says that Prof. Eckhard shares the opinion of Mering and Musculus, that the urine of animals under the influence of chloral never contains sugar. The author has arrived at this conclusion from the following experiments :

After injecting a certain quantity of chloral hydrate under the skin of a dog, the fourth ventricle of the brain was punctured ; no sugar, however, appeared in the urine. In a second animal glycosuria was first produced by puncture of the floor of the fourth ventricle ; chloral was then injected, and sugar disappeared. Glycosuria may be produced reflexly by section of the vagus in the neck and stimulation of proximal extremity ; but the experiment fails in chloralized animals. Similarly no sugar appeared in the urine of a dog made to breathe carbon monoxide, when chloral (five grams) had previously been administered. This evident influence of chloral over the excretion of sugar by the kidneys, has been turned to account in the treatment of diabetes ; in two patients who were subjected to this method of treatment, a marked decrease was observed both in the quantity of urine and in the amount of sugar which it contained.—*Ibid.*

A Theory of Uræmia.

The Glasgow *Medical Journal* gives the following extract of the late theory

of uræmia advocated by Drs. FELTZ and RITTER :

1. The proportion of potassium salts, both in blood and urine, varies with the quantity and quality of the food ; in dogs badly and insufficiently nourished, it falls to the minimum.

2. A special and prolonged alimentation, consisting of materials containing sodium salts, reduces the proportion of the potassium salts to nearly the same degree as bad and insufficient feeding. The demineralization of the blood is greater, as regards potassic salts at least, than when the diet includes potash in some form.

3. The quantity of potassic salts existing in the blood influences to a certain degree the quantity of urea necessary to provoke grave symptoms or death.

4. Suppression of the renal functions by simultaneous ligature of both ureters causes a sensible increase in the proportion of potash salts in the whole blood and in the serum, notwithstanding supplementary gastro-intestinal excretion ; in this respect the alkaline salts follow the same law as urea and extractive matters, both of which are augmented in the blood under similar conditions.

5. The grave symptoms of experimental uræmia not being in proportion to the degree of retention and accumulation of urea or of urinary extractive matters in the blood, and corresponding, on the contrary, to the phenomena produced by the injection of fresh normal urine, or of equivalent solutions of potassium salts, it seems probable that the true toxic agents in cases of so-called uræmia are always the potassium salts which have accumulated in the blood.—*Ibid.*

Uræmia and its Treatment.

In a recent paper in *Le Practicien*, Prof. SÉE lays down the rule that when

a person is attacked with dyspnœa without obvious cause in the thoracic organs, the urine should be examined for albumen. He relates two cases, in which the dyspnœa simulated spasmodic asthma, and was not readily diagnosed on that account. He also publishes notes of the case of a young woman attacked by urgent dyspnœa, with great oppression and cyanosis. There was a faint systolic apex murmur, and a few rales over the lungs posteriorly, but nothing sufficient to account for the symptoms. The urine was very albuminous. There was no œdema. She died in a few days. The kidneys were large and red.

In the *Journal fur Kinderkrankheiten*, of recent date, Dr. Prætorius publishes the details of eleven cases of uræmia treated with *muriate of pilocarpin*, and arrives at the following results:

1. The drug is of distinct value, and should be injected so soon as the symptoms of headache, irregular pulse, vomiting, and diminished secretion of urine appear.

2. Its administration is only contra-indicated in cases of extreme weakness and threatening collapse, or general anasarca.

3. It has no effect in cases of glomerular nephritis; but since this condition cannot be diagnosed by the microscope, its administration should not be prevented.

4. Pilocarpin is not only a diaphoretic, but also has a direct influence on the renal secretions.

Benzoic acid is still relied upon by Dr. Da Costa, of Philadelphia:

R. Acidi benzoici, gr. xx.; syrup tolu, ℥ ij.—M.

Sig.—This much to be given every third-hour, largely diluted with water.—*Ibid.*

The Treatment of the Vertigo of Bright's Disease.

Dr. J. R. SAUNBY says, in the *Brit. Med. Jour.*, even where we cannot hope to effect a cure of the disease itself, it is often of the greatest moment to be able to relieve a symptom which is rendering life worthless. Vertigo is not a very common symptom in chronic Bright's disease; but, though it does not receive much attention from text-book writers, when it is present, it is a very serious matter to the sufferer, and often assumes a pre-eminent position in his own account of himself. After trying various remedies, I have found the greatest benefit from caffeine or theine, in doses of one, two, or three grains, in pill, three times a day. The following cases are examples: S. K., aged 69, complained of severe giddiness, but proved to be a typical case of granular kidney; after taking, without benefit, chloride of ammonium, iodide, and bromide of potassium, he was entirely relieved by caffeine in grain doses three times a day. J. W., aged 63, complained of giddiness, pain in the head, and loss of memory. The ophthalmoscopic signs were negative. The urine was of specific gravity 1.001; it contained a trace of albumen. She had frequent nocturnal micturition. She was ordered at first chloride of ammonium and digitalis; then theine, in doses gradually rising to three grains, three times a day, when the vertigo was completely cured. I have notes before me of two other cases equally satisfactory.—*Ibid.*

Nitro-Glycerine in Bright's Disease.

This agent has been prescribed by Prof. JAMES C. CAMERON, M.D., of Montreal, in a case reported in the *Canada Med. Record*. He used a one-per cent. alcoholic solution, and of this the dose was at first one, and afterwards

two minims, in syrup of tolu. He says of it in this connection: The case after the first month was hopeless, and treatment was only palliative. In carefully reviewing it, my opinion is that nitro-glycerine prolonged life for nearly two months. It increased markedly the quantity of urine passed daily; but although the *relative* amount of albumen was considerably reduced, the *absolute* amount was not too much affected. The œdema and labored breathing were undoubtedly relieved by its use, and the pulse rendered softer and less corded. From the careful and daily study of this case, I am convinced that, in certain conditions, nitro-glycerine is a valuable remedy in the treatment of chronic Bright's disease, and may be administered with perfect safety and without unpleasant symptoms for a considerable length of time.—*Ibid.*

DISEASES OF THE NERVOUS SYSTEM.

The Heart Symptoms of Chorea.

Dr. OCTAVIUS STURGES regards the heart symptoms of chorea, taking them in their entirety, and not by arbitrary selection—the early irregularity, the variable mitral murmur, the very frequent acceleration of heart and pulse, with frequent fluctuations in the rate of both—as being altogether special and peculiar. They are signs of the heart's sympathy with the voluntary muscles, and are seen most frequently at that early time of life when the antecedence of acute rheumatism is the least probable. The heart suffers, by whatever mechanism or nervous influence, together with the rest of the muscular system, or rather it is apt to suffer. In order to understand the conduct of the heart in chorea, we must look to the disease itself and the modifications it exhibits at various ages. The heart is apt

to sympathize with the voluntary muscles at all ages, up to the adult period, this sympathy being shown as well by dynamic murmur as by accelerated action, unevenness of rhythm, and seldom the excited impulse common in hysteria, the particular manner of response being dependent upon the age of the patient. The hypothesis is that these several modes of cardiac affection correspond with as many modifications of chorea, which are exhibited not in the heart only, but in the voluntary muscles as well; these several regions sharing jointly, each in its own degree and after its own manner, in a disorder the area of whose influence is co-extensive with that of ordinary emotional disturbance, and particularly that in all such variations the motor element of the affection is represented mainly by irregularity and unevenness of cardiac rhythm, the emotion element by acceleration, and the paresis element by dynamic murmur.—*Med. Record.*

Hysteria.

Dr. WM. GOODELL (*Clin. News*): When called to treat a young girl with a hysterical attack, there are three things which you had better do: (1) Institute at once firm pressure in the neighborhood of both ovaries. This is very apt to quiet the patient at once. (2) Administer an emetic. I have found that a woman who is well under the action of an emetic has not the opportunity to do anything else than be thoroughly nauseated. Give a full dose of ipecac with one grain of tartar emetic. (3) And this method of controlling the spasm will often act charmingly, take a good-sized lump of ice and press it right down on the nape of the neck. This produces quiet by its powerful impression upon the whole nervous system.—*Louisville Med. Record.*

Notes on Seven Fatal Cases of Hydrophobia.

Mr. SOUTHAM has tabulated his notes of all the cases of hydrophobia seen during two years' term of office in the Manchester Royal Infirmary, and furnishes some items of interest from a clinical point of view. As the treatment cannot be based upon any definite pathological condition which is to be met, it became purely symptomatic, and resolved itself into four principal methods: 1st, by chloral and opium; 2d, by chloroform and curara; 3d, by tracheotomy; 4th, by the hot-air bath. Of the four drugs mentioned, chloral appeared to secure the most beneficial results, prolonging life, and temporarily arresting the spasms. Its administration was readily effected hypodermically, the introduction of the needle causing no spasm. With regard to curara, the author found in two instances that there were alarming symptoms of respiratory weakness, once after one-sixth grain had been administered, and yet the spasms were not relieved. Tracheotomy, which was performed to obviate death from spasm of the glottis, was of little use. In six of the cases death was due to gradual heart-failure, and in only one to spasm of the glottis. In respect to the temperature, it was found in three cases to have risen above 103° F., and in one to above 105° F. The urine of all the cases contained albumen. In three instances there was sugar in the urine, indicating, probably, that some abnormal condition of the medulla oblongata was present.—*Med. Record.*

Nervine and Anti-Spasmodic.

℞. Potassii bromidi, gr. x.—00.66 gm.; tinct. conii, gtt. xxx—2.00 fl. gm.; tinct. val. ammonia, gtt. xx—1.33 fl. gm.; aquæ camph., ʒ j.—30.00 fl. gm. M.

A favorite prescription in the Hospital of Chest Diseases, London. It is useful in epilepsy, dysmenorrhea, chorea, hysteria, and the like.—*Medical Summary.*

Aphrodisiacs.

According to Dr. BARTHOLOW, the following are distinctly aphrodisiac combinations in functional generative debility:

℞. Ergot. extract. aquos., ʒj.; sanguinariae pulv., gr. ij. M.

For twenty pills. One three times a day.

Or, ℞. Tinct. sanguinar., ʒ iij.; stiltingiæ ext., fluid., ʒ v. M.

Fifteen to twenty drops in water, thrice daily.—*Med. and Surg. Reporter.*

DISEASES OF THE RESPIRATORY ORGANS.**Cough of Tuberculosis.**

Dr. WHITEWAY WILKINSON writes to the London *Lancet* that he has frequently been able to afford relief in the early stages of pulmonary tuberculosis by giving the patient, every half hour, alternate doses of sulphate of copper and sulphate of zinc—1.50th of a grain. Without any other drugs the cough gradually gave way.

Curability and Treatment of Pulmonary Phthisis.

Before having proved anatomically (as has been done recently) that tubercle had a natural tendency to heal, the curability of pulmonary phthisis was a clinical fact well demonstrated, and which M. Jacquoud had contributed both in his teachings and in his writings. His new book, dedicated to the curability of consumption, is a new affirmation, more complete and more decisive, to practitioners, and ought to be their con-

stant study. This book furnishes details very interesting and of the greatest value.

In the use of cod-liver oil M. Jacquoud protests energetically against the insufficiency of the doses usually given. Six teaspoonfuls is the minimum dose given by Dr. J. Occasionally larger doses are given, commencing with small and gradually increasing each day so as to reach each week an additional spoonful. Various means are used to produce tolerance of the oil. Alcohol is the best; strychnine and ether are also good.

Fever alone (by reason of the alteration produced in gastric secretion) is a contraindication to cod-liver oil, and then glycerine should be well digested during the fever. As to the hot season, it will be no obstacle to giving the oil. Glycerine, though inferior to cod-liver oil, is a good addition, and given in from 40 to 60 grammes daily, is only contraindicated in persons of cerebro-cardiac excitability, in insomnia, and in high temperature. In addition, give one drop of the essence of mentha, ten grammes of cognac or rum, which makes the mixture more agreeable.

Arsenic is also a remedy which Dr. J. associates with those above mentioned, and is contraindicated when there is lassitude after a walk, and the medicine, if continued, causes feebleness in the lower extremities. This is often the first symptom of arsenical saturation.

Among other remedies, creasote more rapidly and more surely diminishes expectoration and lessens bronchial lesions. This remedy unhappily produces certain difficulties. Commence with small doses say from 3 to 5 grains, and gradually increase. It is better to give it in capsules, or to add to the oil or glycerine containing it a drop of mentha.

The indications for the treatment of fever are variable. Quinine and especially the bromo-hydrate of quinine, is preferred, especially when there are cavernous indications or putrid expectoration, and the salicylic acid is also appropriate. The first day 30 grains of salicylic acid is given, and one-half this quantity each succeeding day. If the fever do not moderate, the dose is continued at 30 grains, in combination with cognac or rum, followed by a glass of water. If there be gastric intolerance, use the salicylate of soda, from 4 to 6 grammes, the first day, with decreasing doses afterwards, or with small doses subcutaneously. D. Jacquoud has studied the employment of benzoate of soda, by inhalations, so much praised by some physicians, but his conclusions are not so favorable as to lead him to continue it.

—*Journal de Therapeut.*

Forced Feeding in Phthisis.

From the London *Lancet* we note, M. Debove has lately urged the importance of the forcible feeding of phthisical patients by means of the œsophageal tube, and his favorable results have been confirmed by M. Dujardin-Beaumetz. In some cases the stomach is first washed out, and then food is introduced, easily digestible—milk, eggs, pounded meat, etc. Patients are said rapidly to regain appetite, strength, and nutrition, and to lose their pyrexia, night-sweats, and vomiting. The tolerance of the stomach for food thus introduced, even in considerable quantity, is said to be remarkable, and even the most troublesome cough no longer causes vomiting. M. Dujardin-Beaumetz has employed for this purpose an œsophageal tube, one-third of an inch in diameter, and gives by it about three and one-third ounces of raw meat, four eggs, and about

two quarts of milk at a time, and four and a half to six fluidounces of cod-liver oil. He prefers to feed the patient in this manner twice in the day, and has also observed under this treatment an improvement in the pulse, a diminution in the fever and in the sweating, but he has not yet observed a decrease in the pulmonary disease.—*Med. and Surg. Reporter.*

Remedies in Consumption.

Dr. R. SAUNDBY (*Practitioner*) recommends in consumption the symptomatic plan of treatment, and tabulates his remedies as follows :

Specific.—Quinine, cod-liver oil.

Cough.—Licorice, camphor, codeia lozenges.

Bronchitis.—Turpentine inhalations.

Purulent Expectoration.—Eucalyptus inhalation, sulphate of iron.

Anorexia.—Quinine, peptonized food, malt extracts, cod-liver oil, ether, alcohol.

Diarrhœa.—Sulphuric acid, starch and opium enema, ergot enema.

Sweating.—Sulphuric acid, atropine, picrotoxin.

Hæmoptysis.—Sulphuric acid, ergot, ergotine.

If the patient be suffering from cough, profuse purulent expectoration, anorexia, diarrhœa, sweating, and slight hæmoptysis, it is very easy to combine the remedies in the following manner :

℞. Quiniæ sulphatis, gr. j.—specific and tonic; ferri sulphatis, gr. v.—for profuse expectoration; acidi sulphurici dil. ℥ xv.—for sweating, diarrhœa, and hæmoptysis; aquam, ad. ℥ j.; fiat mist. ter die sumenda.—M.

This may have a minim of liq. atropiæ sulph. added to each dose if it should not check the sweating. In addition, the patient requires some licorice, camphor, or codeia lozenges, and cod-liver

oil, and perhaps wine; but, so far as medicines are concerned, only one bottle is needed.

If any symptoms should assume greater importance, and not be held in check in this way, all other treatment should be suspended, and the remedies suggested for that symptom should be used alone until it is controlled.—*Ibid.*

Treatment of Tonsillitis.

Dr. DAVIS A. HOGUE, in the *Medical Brief*, cites from the clinical experience of the late Professor J. Aitken Meigs in chronic tonsillitis, the employment of *chromic acid* in the proportion of twenty grains to the fluid-ounce of water, applied to the tonsils by means of a camel's hair pencil.

M. Giné, Professor of Clinical Surgery at Madrid, affirms that bicarbonate of sodium, repeatedly applied topically to the tonsils, has a powerful curative effect in tonsillitis. It may be employed either by insufflation through a paper tube, or the patient can himself apply it with his finger. He states that the cure is rapid, often occurring at the end of twenty-four hours, but usually it is immediate. He recommends it especially in the prodromic period of tonsillitis, as a means of aborting the disease. He considers tonsillotomy as a wholly unnecessary operation in hypertrophy of those organs, for this condition can be entirely subdued, in a relatively short time, by frequent applications of bicarbonate of sodium.—*College and Clinical Record.*

Tonic and Sedative in Chronic Bronchitis of Old People.

℞. Zinci sulphat., grs. xii.—xxiv.; ext. conii, grs. xxxvi.

Make a mass; divide into twelve pills, and order one to be taken three times a day.—*Med. Gazette.*

MEDICINE.

CONSTITUTIONAL DISEASES.

The Action and Uses of Antipyretic Medicines Administered Internally upon Septicemia and Allied Conditions.

By Prof. BINZ, (*Louisville Med. Jour.*)

1. In the present state of our knowledge there are two modes in which antipyretic remedies may be conceived to operate; first, by increasing the discharge of the pyrexial heat; secondly, by checking its production.

2. The quantity of heat discharged may be augmented by direct withdrawal (tepid water), or by facilitating the circulation through the skin (digitalis, cutaneous irritants).

3. The production of heat may be lessened by repeated cooling of the surface, and especially by the internal use of antizymotics.

4. Febrile diseases commonly owe their origin to the introduction and rapid development of substances akin to ferments. Several of these have been shown to resemble yeast in being low vegetable organisms or derived from such organisms. They enter the glands, where they undergo multiplication, increase the metabolic processes, generate products of decomposition, which exert a paralyzing action on the nervous system, and raise the standard of temperature throughout the body.

5. Owing to impaired action of the heart in certain stages of the disorder, or to contraction of the cutaneous vessels, the skin becomes anemic and gives off less heat than usual. The internal temperature rises accordingly.

6. Quinine, our chief antipyretic, acts by directly combatting the efficient

cause of the disorder, and by checking the abnormal metabolism going on in the body. The nervous system takes no part or only a secondary part in this operation. In intermittent fevers quinine prevents the paroxysms by attacking their infective cause. The paroxysms are not the essence—the substantive element—of the disease; they are only a symptom of it. The substantive element is the poison deposited in the colorless corpuscles of many organs, especially the spleen. There are fevers without paroxysms and paroxysms without fever. It is just those intermittent fevers which run their course without paroxysms that are the most malignant. The malarial poison rapidly causes disintegration of the tissues and the blood, and so paralyzes the nerve-centers.

7. The reduction of acute splenic tumors by quinine depends upon the adverse influence exerted by the alkaloid on the infective poison to which the morbid over-action of the spleen and its consequent enlargement are due. "*Cessante causâ cessat effectus.*" Even a healthy spleen may be reduced in size by large doses of quinine; the alkaloid vigorously checking the oxidation of its principal elements, the colorless corpuscles. Quinine has no direct influence on the vasomotor nerves.

8. Quinine attacks the malarial poison with especial energy; on this fact depends the so-called specific action of quinine in intermittent fevers. The same relation, but in a minor degree, subsists between quinine and the infective poison of enteric fever, between mercury and iodine and the poison of syphilis, between salicylic acid and the

"irritant" in acute articular rheumatism.

9. An antipyretic which in one disease instantaneously arrests the fever may be wholly powerless in another. The difference depends on the fact that the various antizymotics act very unequally upon the individual *schizomycetes* and ferments; one will paralyze them rapidly, by another they will hardly be affected.

10. The past history of therapeutics and recent achievements in the domain of etiology and pharmacology entitle us to assume that by persistent scientific inquiry and practical observation we may succeed in discovering a specific antidote for every species of infective or septicemic malady. — *Louisville Med. Journal*.

Cause, Nature and Treatment of Yellow Fever.

Dr. DOMINGOS FREIRE (*Med. & Surg. Reporter*) has published a monograph bearing the above title.

As he found in the dejections, the saliva and the blood of yellow fever patients, numbers of microscopic organisms, bacteria and cryptococci, he comes to the conclusion that the disease is of an infectious nature. And as the salicylate of soda had been much recommended in analogous affections, such as septicæmia, variola and typhoid fever, he determined to investigate its effects in yellow fever.

He had administered the medicament hypodermically, in doses from $2\frac{1}{2}$ to 22 grains, according to the intensity of the fever, in the first period of the malady. In the second period, the dose should be smaller, as it then acts as an antiseptic; it is of no service in the third period, when black vomiting has commenced.

Unusual Case of Typhoid.

Dr. W. C. B. FIFIELD (*Med. Times*) reports an unusual case of typhoid.

When patient (a young man) had recovered sufficiently to move about his room, he experienced a relapse. On arising from this, having reached a similar stage of convalescence, a second relapse occurred on sixty-ninth day. Dr. Fifield called on seventy-third day; found pulse nearly uncountable; temperature 105° F.; discharges involuntary; there was subsultus tendinum; belly very tympanitic, covered with rash, suggesting typhus, though too distinct; patient unconscious. Musk suppositories ameliorated symptoms. Seventy-sixth day, albumen appeared in urine. Musk replaced by small doses of morphia. Observed that whenever a large alvine discharge occurred, temperature fell a little. Seventy-eighth day, patient became violently delirious. About eightieth day, condition was so grave that he was not expected to live through the night. Leaving the house, physician was suddenly recalled, to find patient had fallen into convulsions. A new convulsion appeared as he re-entered room, during which an immense dejection took place. At this juncture temperature fell at such a rate that recovery was predicted, and actually followed. The result suggested that in cases following scarlet fever, in which the urine is albuminous, a strong cathartic action brought about by one, two or three drops of croton oil, will be likely to restore the patient to health.

Turpentine and Carbolic Acid in Typhoid.

Dr. J. F. PEACE (*Med. Brief*) reports fifty-four cases of typhoid fever, of which thirty were treated with carbolic acid, given in one to three drop doses, three to four times per diem, and twenty-four were treated with turpentine, given in five to ten drop doses, three to four times a day. The duration of the disease was shortest in those treated with carbolic acid, and they all recovered. Of those

treated with turpentine two died. The supporting treatment was the same in all.—*Chicago Med. Review.*

Typhoid Fever at Three Years of Age.

DR. CHARLES W. DULLES (*Med. Times*):—On the night of February 24 I was called to see E. C., a little boy 3 years old; who had been taken ill a few days before, with cough, fever, and some constipation. On the day in which I saw him he had been carried to a dispensary, and received from one doctor a prescription of bromide of potash, and from another one of calomel, soda and sugar, for his bowels, and a sedative cough mixture containing paragoric. At the same time his parents were advised that he was too ill to be carried about, and should receive medical attendance at his home.

When I first saw him he had a high fever, a troublesome cough, pupils widely dilated, and some delirium. He fretted and cried out, and picked persistently at his bedclothes.

On examination I found evidences of bronchitis, and some apparent congestion of the upper part of both lungs. I found also a tongue with a heavy, gray, offensive coat. Concluding that it was high time his bowels were well moved, I ordered him to be given five grains of calomel, and that this should be repeated in four hours if no operation ensued.

The next day I found that his bowels were moved, and that the nervous manifestations were somewhat less marked. I ordered him to be given spt. æther. nitros., well diluted, to have only milk for food, and awaited developments. I this day examined his urine, and found it slightly albuminous and loaded with urates, but devoid of casts. The next day I found no appearance of improvement. The tongue was heavily coated,

with red points scattered over it, and with red edges; the lips were parched and scaling; the respirations were 44, and the pulse 130. I found some tenderness in the right iliac fossa. The nervous phenomena were as bad as ever. The child lay picking at the bedclothes, and had phantasy.

I now concluded that the case was one of typhoid fever, and ordered the following mixture:

℞. Acid. sulph. aromat., f 3 j.; acid. carbolic., gtt. iij.; glycerinæ, f 3 jss.

M. Sig.—A teaspoonful every four hours.

I also continued the use of a mixture of spirit of nitre,—a teaspoonful in a tumblerful of water,—giving a tablespoonful every half hour. I also ordered the lips to be kept soft with vaseline, and his tongue to be painted frequently with glycerine,—measures which are so very refreshing to fever-patients that I am surprised occasionally to find medical men who do not regularly employ them.

The next morning (February 27) I found the child's nose bleeding, and that his bowels had been moved at midnight,—a dark, tenacious passage. His lips were still much parched, his tongue was coated as before, his pulse 160, his cough incessant and harrassing. I now ordered tinct. opii deodorat., one drop every two hours till he was quiet, and the carbolic-acid and sulphuric-acid mixture as before. He took four drops of the opium during the day and two at night. The next day (the 28th of February) his pulse was 176, his respirations were 40 and grunting, his cough dry and short. His restlessness was not nearly so marked as before. I then ordered:

℞. Tinct. digitalis, gtt. xij.; syr. scillæ, f 3 j.; liq. ammon. acet., f 3 jss. M. Sig.—f 3 j. every hour.

In the evening he had two stools of a

yellow color, thicker than mush and sticking to the bottom of the chamber. He had passed no urine since noon of the day before.

March 1.—I found a pulse of 172; cough very troublesome. Three stools had been voided during the night and one this morning,—soft, ochre-colored stools. He had voided urine also three times.

The same medicine was continued, and a drop of deodorized tincture of opium given several times during the day.

The next morning (March 2) I found him decidedly better. Pulse 140, respiration 40 and easy, cough very slight. During the night his bowels had been moved once,—a thin, yellow, slimy passage, which stained the sheet as would a salt of iron. The same treatment—of the digitalis, squill, and acetate of ammonia, with the opium p. r. n.—was continued.

The next day he had but one movement, and seemed better. His nose bled again this morning. I now ordered him, for its tonic effect,—

R. Tinct. cardam. comp., f ʒ j.; liq. ammon. acet., f ʒ jss.; syrup simp., f ʒ ss. M. Sig.—f ʒ j. t. d., in water.

During the following twenty-four hours he had five stools, and was given a drop of the opium after each. When I saw him in the morning (March 5), I was somewhat startled at his appearance. He was pallid, breathing superficial, lying asleep with his eyes half open and the pupils contracted. When I aroused him, however, I had the pleasure of seeing the pupils dilate fully, and finding he wanted to have my watch and pencil to play with, as had been his custom before. He was given no opium this day. Between dark and midnight his bowels were moved four times, and I ordered him to have twice a drop of opium,

In the next twenty-four hours his bowels were moved twice, the passages being a little darker and having more consistency. He passed no urine in the latter half of this period.

The next day (March 7) the little fellow was decidedly better. He sat up in bed; his bowels were quiet, his lips were soft, his tongue clearing up, his intelligence perfect, and his spirits rising.

Before March 8 his bowels were twice moved, with an appearance more natural; his cough was much less troublesome. The medicine prescribed March 4 was still being given. I found, this morning, a fine crop of sudamina on the abdomen.

March 9.—The boy was still better, sitting up in bed and playing with his toys. His bowels had been moved once since the day before. His medicine was continued t. d., and careful avoidance of strain enjoined, while his food was still restricted to milk.

March 10.—His bowels were moved but once in the foregoing twenty-four hours. The stool was small, brownish, and partly formed. His pulse was now 104, and his cough inconsiderable.

After this his convalescence progressed steadily.

The chief points of interest in this case seem to me to be the following:

1. The early development of delirium.
2. The unusually troublesome character of the lung-complication.
3. The effect of the free use of opium.
4. The rapid convalescence, occurring within two weeks of the seizure.
5. The determination of the nature of the disease.

Simple Continued Fever.

R. Acid. Hydrobrom., ʒ i; Syr. Simplic., ʒ ii; Aq. ad. ʒ i. M. Sig. Every hour.—Fothergill. Dr. Fothergill, in

speaking of the above formula, says it will probably constitute, *par excellence*, the fever mixture of the future. It is especially indicated where there is cerebral disturbance.—*N. Y. Medical Record*.

Salicylate of Soda in Variola.

In the *Bulletin de Thérapeutique*, Dr. BAUDON publishes the good results he has obtained in three cases of variola, by the use of the salicylic method. The first case was that of a man, 72 years old, who had been vaccinated in early youth. After three days, the face principally, and the whole body, showed signs of such an exuberant eruption as to warrant a most unfavorable prognosis. The case announced itself as one of confluent variola. The patient was in a state of great agitation, and it was a difficult matter to keep him in bed. Wine and brandy were prescribed, and taken without much trouble. So abundant was the eruption that the Doctor feared when suppuration set in the smell would be intolerable, and might prove infectious to the whole system. To guard against this, when that period drew near, the face and a great part of the body were anointed, thrice daily, with the following ointment: *R.* Cold cream, \mathfrak{z} iij; Salicylate of soda, \mathfrak{z} j. *M.* Besides this, the whole surface was dusted over with: *R.* Talc, \mathfrak{z} iij; Salicylic acid, \mathfrak{z} iss. *M.* The next day Dr. Baudon found the pustules had not increased in size, and the day after they began pitting; no pus was formed, nor was any smell developed. The parts not covered with ointment and powder underwent slight suppuration. Desiccation took place as usual, but the Doctor believed that the course adopted had averted serious impending results, among which the dangers to the attendants from the putrid smell were not the least.

Delirium only lasted about three days, and ceased when the vesicles began pitting.

The daughter of the above patient was the next victim; she had been vaccinated but once. She was twenty-three years old, and her case was one of simple variola, although the eruption over the face was very abundant. Immediate applications of the ointment and powder soon brought about an abortment of the pustules.

The third case was that of a man thirty-five years old, of weak constitution, who also had been vaccinated in infancy. The whole surface was covered with pustules. The ointment and powder were applied, and besides a tablespoonful of the following mixture was prescribed, to be taken every two hours: *R.* Distilled water, \mathfrak{f} \mathfrak{z} iv; salicylate of soda, \mathfrak{z} j; syrup, \mathfrak{f} \mathfrak{z} viiss. *M.* Much to the doctor's disappointment, the patient only took one spoonful of this mixture. Nevertheless, he soon recovered. Desiccation was rapid, and no pustules formed on the face.

In conclusion, we may say, that the foregoing method can do no harm, even if it has no other advantage than to do away with the repulsive exhalations, which are a source of danger to those around the patient.—*Med. and Surg. Reporter*.

Variola.

DR. R. W. PEACOCK (*Med. Brief*): I have treated between thirty and forty cases within the last three months, none of them pock marked; the remedies prevent, in a great measure, the intolerable itching during the eruptive stage of the disease, and prevent the secondary fever, hence a larger percentage get well. I put all my cases on the following treatment at first, and continue it until all the scabs fall off: *R.* Sodæ hyposulph.,

2 ounces; aquæ, q. s.; syr. simp., q. s. ft., 8 ounces. M. Sig.: One teaspoonful every three hours. R. Bitartrate of potass., 2 ounces; aquæ, 2 pints. M. Sig.: One wineglassful two or three times a day. R. Carbolic acid, 2 drachms; vaseline, 8 ounces. M. Sig.: For external use, three times a day; have patient well rubbed with ointment every day until the scabs fall off.

Borax in Erysipelas.

DR. F. H. ATKINS, Fort Stanton, New Mexico (*Philadelphia Medical Times*), claims very good results in erysipelas from the use of a solution of borax in glycerine, one drachm to the ounce. The borax was sometimes used in conjunction with tincture of perchloride of iron, sometimes not.—*Chic. Med. Rev.*

Clinical Researches and Experiments upon the Pathology of Erysipelas.

D. DUPEYRAT (*Lyon Méd.*) bears out the experiments of Dr. Orth, as demonstrating the parasitic nature of erysipelas. The conclusions with which he terminates his thesis are as follows: (1.) Erysipelas is due to a living substance strange to the organism, and capable of reproducing itself in the economy. (2.) This material or substance is a spherical bacterium, isolated or united like beads, but always fixed. (3.) This immobility is a characteristic which he believes to be pathognomic of the bacteria of erysipelas. (4.) This bacterium is the only one which seems to be able to produce erysipelas. (5.) This germ is incapable of flourishing in all subjects, certain individuals affording a more favorable soil for its development. (6.) A wound is necessary for the penetration of the germ into the economy. (7.) Artificial erysipelas can only be produced in animals by the specific bacteria. (8.) The serum of an erysipelatous bulla, deprived

of its bacteria, cannot produce this exanthem.—*Glasgow Med. Jour.*—*N. Y. Med. Abstract.*

Scrofula and Tuberculosis.

The *Medical Times and Gazette* says that M. GRANCHER recently made to the Société Médicale des Hospitaux of Paris an interesting communication on the above subject. The following are his general conclusions: 1. Tubercle is a fibrocaseous neoplasm, the development of which takes place in successive stages, during a longer or shorter period; this complete evolution may be accomplished in a few months, or it may last throughout the whole of life. It may, however, be arrested during the earlier stages, and never get beyond them. 2. Pathological anatomy and experimental pathology are to-day agreed to include under the term tuberculosis the greater number of affections called scrofulous, as local tubercloses. 3. Lupus, and superficial inflammations of the skin and mucous membranes, the last resort of those who persist in regarding scrofula and tuberculosis as distinct, will probably be included in the same order in due process of time. 4. The necessities of practical medicine, which, after all, must first be reckoned with, do not permit all tubercular affections to be confounded together; on this account it is convenient to retain the word "scrofula" for those tuberculous affections which are very slight and generally curable.—*Med. & Surg. Reporter.*

Tubercle.

SIDNEY COUPLAND, M.D. F.R.C.P. (*Can. Med. & Surg. Jour.*)

1. Tuberculosis is an infective disease to which man and the higher animals are liable.

2. It is characterized anatomically by the formation of minute nodules or

"granulations," composed of elements like those met with in granulation tissue, the result of simple reparative inflammation.

3. These nodules, or elementary or primary "tubercles," may occur in an isolated manner, or, by their confluence, may form larger or smaller conglomerate masses.

4. The typical structure of each fully formed primary nodule consists (*a*) in a collection of lymphoid round cells, inclosed in a delicate fibrillar meshwork or stroma; (*b*) in an internal zone, more or less evident, of larger nucleated epithelioid cells; and (*c*) a central multi-nucleated or giant cell.

5. These "tubercles" arise apparently in connection with the lymphatic tissue that pervades the body. No region is exempt from them. They may occur in the substance of organs, in the bones and muscles, in serous membranes, as the pia-arachnoid, pleura, pericardium, and peritoneum; in synovial membranes; in mucous membranes (arising in the submucous stratum), as in the mouth, pharynx, larynx, trachea, bronchi, intestines, and genito-urinary tract.

6. Being ill supplied with blood-vessels, they can only attain a certain size, and then perish. The central cells degenerate first, because they are the farthest removed from the nutrient blood stream, and mutual pressure due to their increasing growth hampers their vital activity. They become fattily degenerated, soft, opaque, caseous, forming "yellow" tubercles, which, when isolated, are larger and manifestly of older formation than the milary translucent grey granules. Where such tubercles are confluent, larger and more irregular caseous masses are formed. Caseation may pass into cretification. On the other hand, there is no doubt that occasionally the tubercular nodules take on

a fibroid change, passing from the stage of "granulation tissue" to one resembling "cicatrical tissue."

7. Almost invariably there occurs, in the vicinity of the tubercular formation, some reactive inflammation. This may be protective by ultimately leading to encapsulation by fibrous tissue of the caseated tubercular focus; or, as more frequently happens, it aids in the disintegration of the surrounding tissues, and leads, with the necrosis of the tubercles themselves, to destructive ulceration.

8. Individuals who are prone to the development of tubercle are called "tubercular." The disposition may be inherited. Probably what we recognize as "struma" or "scrofula" is only one form of this: a tendency to tuberculosis of lymphatic glands especially; just as in phthisical subjects we have a tendency to pulmonary tuberculosis.

9. The tubercular manifestation is, in the majority of cases, at first local, *i. e.*, limited to one organ or tissue. It may remain so limited throughout life—may not even endanger life—or may lead to death by the local destruction to which it gives rise. On the other hand, it may be more or less widely diffused throughout the body of the same individual. This diffusion may be due sometimes to the simultaneous development of tuberculosis in many parts. More frequently it is due to secondary dissemination by a process of infection.

10. This dissemination takes place, as in cancer, in two ways, *viz.*, by direct extension, or infection of neighboring tissues by contiguity, and by general distribution of the tubercular virus through the medium of the blood-system (including lymphatics).

11. The tubercular virus seems to be most potent, or, at any rate, to retain its

potency, *i. e.*, its infective property, in the caseous state.

12. Examples of the local extension of tubercle, or of propagation by contiguous infection, are seen (1) in the development of peritoneal tubercle from intestinal; (2) in the spreading of tubercle from one part of an organ (*i. e.*, lung) to another part; (3) in extension from lung to pleura; (4) in bronchial, laryngeal and intestinal ulceration excited by the passage over their mucous membrane of material expectorated from a phthisical lung; (5) in tuberculosis of bladder and vesiculæ seminales following upon renal or testicular tubercle, etc. The mode of its local extension approximates tubercle to the neoplasma, viz., by its elements exciting in the tissue they infect changes leading to the formation of cell-masses resembling the primary focus.

13. The generalization of tubercle is shown in the disease known as acute miliary tuberculosis, which is characterized by an eruption of miliary granulations in diverse organs and tissues. Its mode of occurrence may be (as above) compared to the general dissemination of secondary cancer, or, perhaps with equal truth, to the metastatic suppuration of pyæmia. With few exceptions, it appears to necessitate a primary tubercular focus to give rise to it. It is believed that the infective virus, whatever it be, enters the blood-stream at this local focus, and is thence widely disseminated, the resulting growths being for the most part miliary, grey, and translucent; life not, as a rule, being prolonged for a sufficient length of time after the occurrence of the generalization to permit of the growths becoming confluent or caseous. As the membranes of the brain are generally involved in this widespread infection, death occurs early.

14. Lastly, tuberculosis is inoculable. In this respect it resembles pyæmia and differs from the cancers; for there is reason to think that it may be and is communicated from one human being to another, *e. g.*, from husband to wife, and *vice versa*, and that it can be inoculated in animals from man (artificial tubercle). There is, further, a possibility, based on certain peculiar morphological resemblances of the formations, that bovine tuberculosis is communicable to man.

15. If the foregoing data be true, it follows that tuberculosis is an infective disease, probably due to the presence of a virus, which gives rise to the development of peculiar tissue-formations, capable of localized or general propagation in the body, and characterized mainly by their tendency to early disintegration.

16. Until the nature of the virus is known, it is impossible to formulate data concerning the conditions under which the disease arises in subjects free from inherited taint.

Diphtheria.

Drs. H. C. WOOD and H. F. FORMAD conclude their elaborate investigations on diphtheria in the supplement to the *National Board of Health Bulletin*, as follows :

In finally considering the nature of diphtheria the facts which have been established should be carefully thought over. They may be stated as follows :

The micrococci of diphtheria do not differ, so far as observed, from the micrococci of furred tongue, &c., except in their tendency to grow in culture fluids.

The micrococci of furred tongue or ordinary sore throat have a less tendency to grow under culture than have the

micrococci of endemic non-malignant diphtheria.

The micrococci of endemic or non-malignant diphtheria have a much less tendency to grow under culture than have the micrococci of malignant diphtheria.

The rapidity of growth of the micrococci is in direct proportion to the malignancy of the case yielding them, and its contagiousness.

On exposure to the air diphtheritic membrane of the most virulent type loses its contagious power, and the micrococci *pari passu* lose their power of growing in culture fluids.

Under successive generations of artificial culture the diphtheritic micrococci lose their growth, activity, and also their power of infecting the rabbit.

It has not been experimentally directly proven, but it is a necessary inference from the two facts just stated, that under certain favoring circumstances the sluggish micrococcus puts on growth—activity, and, in all probability, *poisonous properties*.

Every grade of case can be found in man from an ordinary sore throat, through simple pseudo-membranous angina and trachitis, up to malignant diphtheria.

Any inflammation of the trachea of sufficient intensity may cause the formation of a pseudo-membrane.

A case may begin as one of sthenic "pseudo-membranous croup" and end as one of adynamic "diphtheria" with blood-poisoning; and in cases of this character not infrequently no exposure to contagion is discoverable, and there is clinically every reason to believe that the blood poison has been developed within the body of the patient. The theory of the disease which we would deduce from these facts is that the micrococcus, which directly or indirectly

causes diphtheria, is not a specific organism different from that common to healthy and inflamed throats, but is an active state of that organism; that certain circumstances outside of the human body are capable of throwing this common micrococcus into this condition of active growth and engendering an epidemic of diphtheria. When diphtheria is thus epidemic the micrococci light upon a throat, and if the throat have little resisting power, as in the child, inflame it or increase a catarrh already existing into a violent inflammation, and also rapidly enter the blood and cause systematic poisoning.

On the other hand, a catarrh in a weakly subject may, in the beginning, be simply an inflammation from cold, but the ordinary micrococci in the throat or mouth, favored by the special conditions, &c., may gradually change from the dormant to the active state, and by and by act upon the throat, and at last force their way into the system, and a self-generated diphtheria be formed out of a "cold."

It has already been abundantly proven that there is no specific character detectable in the micrococci of diphtheria. The history of wounds infected with diphtheritic poison and of those infected with hospital gangrene, lends further countenance to the idea that diphtheria and certain other septic diseases are really different manifestations of the one affection, the difference in symptoms depending rather upon the difference in the location than in a difference of the nature of the septic process.

Purpura.

R. Vin. ferri., $\frac{3}{4}$ iv.; liq., arsenicalis; min. xx.; syr zingiberis, $\frac{3}{4}$ ij.

M. Sig., one-sixth part, with three tablespoonfuls of water three times a day, after meals.—*Med. Gazette*.

Is Alcohol a Food? When should Malt Liquors be preferred to Wines and Spirits in the Treatment of Disease?

Dr. H. T. WOOD, (*Phil. Med. Times.*)

In answer to this question Dr. Wood gives a *broader* definition to the word *food*, not restricting it to "substances which, either in their entirety or in a more or less altered condition, are capable of being formed into the bodily structure." He claims that in *addition* to this, that that which produces *force*, or has *force-production* in it, is also a *food*. "From this point of view," he says, "any substance which is destroyed in the system, and during the destruction yields *force* is a *food*. The evidence that alcohol fulfils both these conditions is most positive, so positive, indeed, that there is probably no one that would deny, at least, that alcohol is burnt up in the body; and, if it be burnt up, *it must yield heat, i. e. force.*" In chronic wasting diseases, the author says: "I believe alcohol has an actual food value, being a powerful aid to the digestion of other food."

The question as to the best method of administering alcohol when it is used for sustaining powers is of vital interest.

Two general propositions will, I believe, command almost universal assent. First, the alcohol must be given in a dilute form; second, it should be given with other food. Provided these two rules are observed, I do not think it makes much difference in what form the drug is administered. In chronic diseases malt liquors have both advantages and disadvantages. They represent food and drink, are less apt to be abused than are stronger liquids, and by virtue of their bitterness have some tonic properties; on the other hand, they sometimes disagree with the stomach. As they contain some nutritive material,

there is perhaps more tendency to administer them apart from food than there should be. The amount of solid constituents in a pint of malt liquor varies from over two and a half ounces of dry residue in the strongest English ales to three-quarters of an ounce in the weakest ales and beers. The ales and beers usually drunk in this city probably range from one to two ounces of solid contents to the pint. The nature of much of this solid matter is not known, but albumen, bitter and resinous principles from the hop, earthy salts, grape-sugar, glycerin, and a number of complex acids have been recognized in it. The tendency to grossness seen in beer-drinkers undoubtedly largely depends upon the solid constituents of the beer which is taken, and seems to me to indicate the proper medical use of malt liquors,—namely, that they are specially to be employed in wasting diseases, *i. e.*, where there is a tendency to the loss of the bodily fat.

In regard to the choice of malt liquors, I think that which suits the palate best usually suits also the stomach best. The choice should always settle upon the ale, porter, or beer which can be used with least inconvenience to the stomach; and when all malt liquors produce "biliousness," *i. e.*, gastro-intestinal derangement,—wine or diluted spirits should be substituted. As the malt liquors contain nutritive material, it is less necessary to give food with them than it is with whisky or wines. Nevertheless, it is preferable in most cases that food should be taken with the ale or beer.—

DISEASES OF THE NERVOUS SYSTEM.

Sciatica.

Dr. J. H. HUTCHINSON, Penn. Hosp. (*Med. Times*). A. G., single and a domestic. Two years ago she contracted

malaria. Last August she, after sitting on a cold marble, suffered from pains in back, which, after lasting for the space of three weeks, passed into the right leg, in which limb the pain gave rise to so much distress as seriously to interfere with her walking. Her general health was otherwise good. Upon examining the heart and lungs, I found the signs all negative. The pain, we find, shoots along the course of the right sciatic nerve; she walks lame, and the skin is tender on pressure slightly made. Now, there may be in these cases of sciatica, some difficulty in arriving at a diagnosis. In the first place, we may be disposed to view a case as one of gluteal rheumatism when these muscles are primarily and seemingly most involved, and when the pain commences, as it did here, as a sharp, shooting, rheumatic pain, and then degenerates into a mere soreness, more or less localized; but this error may be easily avoided in one way. Notice how your patients trace out for you the course and direction of the painful sensations; they will unerringly trace out the course of the sciatic nerve, and insist that in a certain line is always the seat of pain. When such a history is presented for your consideration, you may rest assured that there is disease or neuralgia of the sciatic nerve. While this patient presented this condition of pain along the upper course of the sciatic nerve, together with tenderness of the skin, she was also found to present certain hyperæsthetic spots, localized over the points of emergence of branches of the sciatic, at the head of the fibula, and over the malleoli. These symptoms may be said to be pathognomonic of sciatica, and are apt to be associated with convulsive twitchings of the muscles of the leg. In addition to these symptoms, we find that she complains of uncertainty in walking; this is

due to loss of the sense of touch, or anæsthesia of the foot, which renders her unable to feel distinctly the floor or ground.

Analgesia, as well as anæsthesia, may be present in these cases. In these cases the first cause of the trouble—the exciting cause, as we say—is nearly if not quite always cold, applied commonly locally, as by resting on damp ground, stone steps, etc., the first effect generally being the production of a muscular rheumatism. Shortly afterwards we find that the skin in spots over the sciatic is giving evidence of an hyperæsthetic condition, this symptom being shortly followed by the well-defined course of pain in the sciatic nerve anæsthesia, analgesia, muscular twitching and loss of muscular power, which in reality is apparent only, and not real, being due solely to the great pain experienced by the patient in locomotion. If, however, the disease last for some time, without the patient obtaining adequate relief, a real loss of power follows. Now, in addition to cold as a producing agency in sciatica, there is another factor that may occasionally be the starting-point of the diseased action. We find here a woman who, having lived in a malarial section of the country for a season, contracted chills and fever. Following upon the development of this malarial outbreak, which was characterized also by frontal or orbital headache, which hemicrania in such cases is named brow ache, we find an attack of sciatica making its appearance. There can be no doubt that malaria pure and simple may in a given number of instances produce inflammatory actions in the sciatic nerve and its sheath, the poison exploding in its virulence upon these structures in preference to its more common seat in the frontal and orbital region. Either one of these neuralgias will get well, and

get well comparatively rapidly, upon the almost specific treatment of malarial troubles—namely, quinine. But in this case quinine alone did not seem to answer the purpose completely. While there was some slight improvement, it was not such a gratifying result of treatment as would be produced if malaria alone was being dealt with. Under such circumstances we are justified in supposing that the disease, having failed to respond to the therapeutic test for the presence of malaria, did not owe its origin to that cause, but that some other agent must be sought for to explain the production of the symptoms present. Now, the other most common cause of sciatica is the presence of the rheumatic poison, which may seize upon the nerve-sheath, which, swelling and giving rise to exudations, etc., produces pressure upon the nerve, thus giving rise to pain in the body of the nerve, while at the same time permitting of the production of anæsthetic and analgesic effects.

Iodide of potassium in such cases is beyond doubt one of the best agents we possess to influence the systemic poisoning, used either alone or coupled with the salicylates; the iodide must be given in decided doses, and pushed till good results are obtained—that is, provided the stomach does not rebel, nor the system show saturation by means of the iodide eruption. Along the course of the nerve blisters can be employed very advantageously. Of course, when the pain is intense, we may have to resort to hypodermic medication. In all these cases, however, there at length comes a time when internal medication seems to cease to be of any avail; we must then resort to other means of influencing the diseased action, which, having reached a certain point, seems to come to a stand-still. It is at this time that electricity, in the form of the continuous

current, comes into play. Where the system is more or less depressed, it must be built up by tonics, etc. In the case we are considering, in addition to the iodide the patient had administered to her six grains of quinine in the twenty-four hours, purely for its tonic effect. Under the treatment I have described, she has progressively improved.

Sciatica.

BILLROTH treats sciatica by subcutaneous nerve-stretching. The patient is placed flat upon his back, the leg extended, and then the thigh flexed strongly upon the trunk. This puts the sciatic nerve strongly on the stretch.

Epilepsy.

DR. ALLEN MCCLANE HAMILTON'S prescription for epilepsy:

R. Strychniæ sulph., gr. j.; fl. ext. ergotæ, ʒ ss.; liq. potass. arsenat., ʒ ij; sodii bromid., ʒ ss.; tr. digitalis, ʒ iij.; aquæ menth. pip. ad., ʒ iv. M.

Sig.—A teaspoonful, before eating, in a half tumblerful of water.

The Diagnostic Significance of a Dilated and Mobile Pupil in Epilepsy.

DR. L. C. GRAY, in the *Amer. Journal of Neurology and Psychiatry*, says that in all the cases of epilepsy which he has examined, a dilated and mobile pupil has been present, and by means of the symptoms he has several times made a diagnosis in *obscure cases*, in which the subsequent history has borne out the diagnosis.

Premonitions of Epilepsy.

In the course of an article on epilepsy, in the *Practitioner* for February, Dr. RADCLIFFE furnishes the following as premonitory symptoms of an epileptic seizure, and the relative frequency with

which each has occurred in his own experience:

Involuntary jerkings, startings and spasms, 38; vertigo, 34; unusual craving for food, 29; unusual sleepiness, 26; respiratory pauses, followed by long breaths, 20; hallucinations, 12; nightmare, 12; frequent pertes seminales, 12; rolling of the eyes, 5; grinding of the teeth, 4; palpitation of the heart, 4; headache, 3; tingling or numbness, 2.—*Med. and Surg. Reporter.*

Treatment of Epilepsy.

M. BALL, the present professor of mental diseases at the Paris School of Medicine, considers that the drugs most used in epilepsy prove much more efficacious, when taken in combination with each other, than when one of them is administered singly. The alkaline bromides, particularly the bromide of ammonium, with belladonna and oxide of zinc, form the basis of treatment.

The following solution may be given, in tablespoonful doses:

℞. Ammonii bromid., ʒ iiss.; sodii bromid., ʒ iiss.; aquæ destil., f ʒ x. M.

At the commencement of treatment four tablespoonfuls of this solution may be taken during the day, and the dose increased to eight or ten tablespoonfuls if no appreciable effect is noticed after a few days.

Belladonna and oxide of zinc are administered, in pill form, as follows:

℞. Ext. belladonnæ, gr.xv.; zinci oxid., gr.xv.; ft. pil. xl. M.

Sig.—One pill may be taken in the morning, another in the evening, at first; then the dose may be increased to four pills per diem.

If any degree of plethora exists the drastic purgatives should be resorted to, and in some cases benefit is obtained from a general bleeding, or the applica-

tion of leeches to the temples or behind the ears.

M. Ball gives the following formula for drastic pills:

℞. Aloes, gr.xv.; scammon. resin, gr.viiss.; jalapæ resin, gr.viiss.; calomel, gr.viiss.; saponis medic., q. s. M. Ft. pil., xxiv.

Sig.—These pills are to be taken once a week, three in the morning and as many more about noonday.

What is of importance to notice is the immediate beneficial effect of this combined treatment; this is sometimes remarked on the second day.

This method, like all other forms of treatment of epilepsy, should be continued for a long period, and should not be suddenly stopped; the doses should be progressively and slowly diminished when it is considered safe to lay aside the treatment.—*Ibid.*

DISEASES OF THE RESPIRATORY ORGANS.

Treatment of Pneumonia at Bellevue.

The chief indication is to sustain the powers and stimulate the functions of the patient till the comparatively brief self-limited disease shall have spent itself. The *pulse* is taken rather than the *temperature*, as a gauge which best indicates the capacity for resistance, and an increase in its rapidity and diminution in its force are understood as a call for stimulants. Whiskey and carbonate of ammonia are the stimulants used.

The forms of stimulation used are to some extent subject to differences of opinion on the part of the visiting physicians, but all are agreed as to the value of whiskey, and there is almost as much unanimity in their regard for the carbonate of ammonium. Digitalis is much used; but it is objected to by some,

partly because experience seems to indicate that in some cases, when the crisis of the disease has passed, patients are left, after its use, in a condition less favorable for recovery, and partly from the theoretical consideration that this drug is not general enough in its action. Camphor has been employed by some as a diffusible stimulant.

The general treatment of pneumonia is then by simply stimulation. In special conditions, however, more is done. When the patient is first seen, if he is suffering from considerable pain, a few doses of morphia are recommended.

If the disease is seen at its outset, and if the outset is violent in character, one at least of the leading physicians on the visiting staff believes in the good effect of a few doses of aconite, but its use is not general in the hospital. The spirit of Mindererus, sweet spirit of nitre, calomel, and Dover's powder, are used by some in the first stage of the disease. Quinine is occasionally called upon to bring down the temperature when it rises to a serious height. One of the visiting physicians makes a special point of the importance of watching the kidneys and seeing that they perform their duty well.

The appearance of œdema of the lungs finds all agreed upon the necessity of crowding the stimulants. But beyond this there are some differences of practice. They would be included in the use of dry cups, the hot pack, oxygen, and, in the few cases which are entirely suitable for it, bleeding.—*Med. Record.*

Antiseptic Treatment of Lung Disease.

Dr. W. V. SNOW.—(*Med. Herald.*)

For several years, I have largely employed dry antiseptic inhalation in phthisis, as an adjunct to general constitutional measures. The treatment I

believe to be useful; but every case of improvement must not be attributed to the inhalation. The most suitable cases are those attended with profuse expectoration, especially when softening has commenced or cavities formed.

The effect is sedative; in a large proportion of cases, the expectoration diminishes in quantity and improves in quality, cough becomes less frequent and severe, and sounder sleep is enjoyed, enabling the patient to dispense with objectionable cough-medicines. The same effects may be noted when the general progress of the lung affection is not arrested. I have never seen hæmoptysis produced by its use. As a respirator, I prefer a simple tin box, perforated, and shaped to the mouth, introduced by Dr. Roberts, of Manchester. The patient is directed to place a few drops of the carbolic solution on tow in the box, and to use the respirator for ten minutes after the morning cough, and at intervals during the day, many habitually use it for hours while reading. If dryness and irritation of the mouth and throat be caused by the carbolic inhalation other remedies may be substituted—such as terebene and encolyptus oil, to produce an aseptic atmosphere, the constant use of the vapor of carbolic acid in the sick-room has been recommended; few can be induced to submit to this treatment, which I cannot recommend.

Dyspnoea of Phthisis and Emphysema.

R. Ext. stramonii, grs. iij; ext. hyoscyami, grs. xx.; ext. lupuli, grs. xl.

M. and divide into twelve pills—one to be taken every four hours until relief is obtained.—*Med. Gazette.*

Iodoform in Pulmonary Diseases.

Prof CIARAMELLI has found iodoform efficacious in broncho-pulmonary affec-

tions, chronic bronchitis with bronchorrhœa, in pulmonary emphysema and in the tuberculosis of infants. He uses the following formula :

R. Iodoform, gr. iss.; lycopodii pulv., gr. viij.; ext. seminis fœniculi, gr. xv.

M. Make ten pills. S.—One every three to five hours for an adult.—*Revista Ital. di Terop., etc.—Jour. Mat. Med.*

In Incipient Phthisis.

R. Pil. ferri carbonatis, grs. 60; ext. conii, grs. 36-60.

Mix and divide into twenty-four pills. Two to be taken twice or thrice daily.

Homatropin in the Treatment of Phthisis.

Dr. FROUMÜLLER reports (*Memorabilien*) sixteen cases of phthisis with night sweats in which homatropin was successfully used. The usual dose was .15 (gr. iiss.) in pill form, or .015 (gr. i-4) by injection. It was found that one injection would, as a rule, stop the night-sweats for several days. The fever and cough were also lessened, and the drug seemed to have the effect of bringing the disease to a stand-still for a time. The advantage over atropin is that it (homatropin) produces its effects without any toxic symptoms, such as widening of the pupil, dryness of the throat, etc. The maximum dose is gr. 1-2 to gr. i. by injection.—*Med. Record.*

Apyretic Hæmoptysis of Tuberculosis.

Dr. JACCOUD (*Deutsche Medizinische Zeitung*) claims that in cases of apyretic hæmoptysis in tubercular subjects he has secured good results from the use of the following mixture: Ergotine, one gramme; glycerine and distilled water, each four grammes, and cherry laurel water two grammes. Of this, a quarter of a hypodermic syringefull should be injected twice, thrice or four times daily, as may be found necessary by the require-

ments of the case. This treatment seems likely to be of benefit in such cases.—*Chic. Med. Rev.*

Ammoniacal Inhalations in Pulmonary Phthisis and Chronic Bronchitis.

Dr. L. M. SWEETMAN (*Can. Jour. Med. Sciences*) has tried the treatment recommended by Dr. Melsens recently, of wearing outside of the shirt and over the upper part of the sternum, a bag containing some pieces of carbonate of ammonia, in cases of distressing cough arising from diseases of the respiratory organs. He says: "I adopted this treatment in the case of two patients tormented with a distressing cough, one due to tubercular, the other to simple chronic bronchitis. During the first night one of the patients complained of a sense of suffocation and fullness of the head; on the day following, however, the cough appeared less troublesome in both cases, and at the end of ten days their sleep became comparatively undisturbed, and the feeling of lassitude vanished to a certain extent—expectoration became diminished in quantity, and instead of being greenish in color became almost white and frothy in the one and disappeared in the other. In twelve days the carbonate of ammonia—about 3 iv.—had become entirely volatilized, the bags not being refilled. Before a week had elapsed, both patients were anxious to resume treatment, one on account of nasal catarrh, and both for the relief of cough which had increased while the treatment was omitted. The ammoniacal inhalation has since been resumed with the usual improvement. We are inclined to believe that in this form of inhalation we have a remedy calculated to palliate—in the majority of cases—that most distressing symptom of a disease so constantly fatal, and over whose course we have so little control."

Myoœdema.

Idio-muscular contraction or myoœdema is the name given to the phenomenon produced in a muscle when a sudden local stimulus is applied to it, as the tap of the index finger, causing a small quickly-vanishing nodule to appear at the part struck.

Its seat of predilection is the front of the thorax, where it may best be produced by a sharp, sudden stroke of the index finger. After four or five shocks, the muscle becomes exhausted, and requires fifteen or thirty minutes' rest before it will again respond to the stimulus. Physiologically, its volume is that of a lentil or coffee bean, its duration two or three seconds, and it is produced equally upon either side of the thorax. Pathologically, its duration is exaggerated to five or fifteen seconds, its size increased to that of a nutmeg, an olive, or an almond, and it is unequal upon the two sides of the thorax.

Lawson Tait describes two varieties: 1st. The most common, the instantaneous production of the nodule upon the part struck; 2d. Storr's nodule, produced by the meeting of two contractile muscular currents, which set out from opposite extremities of the muscular fibres.

Lawson Tait considers that myoœdema is a certain sign of pulmonary tuberculosis, both in its fully developed and latent forms. He also considers that it is a certain indication of a softening tubercle deposit, and that its intensity bears a direct ratio to the rapidity and to the amount of pulmonary destruction. The phenomenon is always more marked upon the side which is the more diseased. M. Labbé's researches have not led him to agree with these views *in toto*. He believes that myoœdema ought to attract attention to the chest and lungs—he states that this sign was the first

that drew his attention to the lungs in many cases, but that in many others the sign was coincident with advanced lesions.

He concludes that it is not the exclusive appanage of pulmonary tuberculosis, nor still less of tubercular softening, having been observed in pleurisy, pneumonia, and enteric fever, and that, without being a decisive sign, it ought to be admonitory and may be confirmatory.

DISEASES OF THE CIRCULATING ORGANS.

Latent Mitral Stenosis.

M. FABRE, of Marseilles, calls attention to the frequent occurrence among girls of mitral stenosis, which remains latent until the attention is called to the heart by a chorea, a rheumatism, or even an embolus. We set the functional troubles, palpitations, to the account of anemia, of a nervous state; and misunderstand the true nature of it. It is of great interest, however, to recognize the cardiac affection early, in order to keep off, as far as possible, asystolic troubles by a well ordered hygiene, and especially to avoid favoring them by marriage, pregnancy having a most disastrous effect upon disease of the heart. Two principal signs will point to the correct diagnosis from the beginning, viz.: habitual frequency of the pulse without elevation of the temperature, and auscultation in the axilla. At the beginning, in fact, the classical signs are lacking at the apex; but toward the axilla, immediately behind the breast, it will be observed that the first sound is duller, more prolonged, than in the normal state; the second sound, on the contrary, is sharper; the silence has a diminished duration.—*Gazette des hôpitaux: L'Union Med.—St. Louis Cour. of Medicine.*

M E D I C I N E .

CONSTITUTIONAL DISEASES.

The Typhoid Bacillus.

EBERTH (*Virchow's Archiv.* Band lxxxiii., p. 486), gives the results of the examination of 17 cases of typhoid fever, with reference to the presence of bacilli. He compares these with 11 other cases of different infectious diseases, in which micrococci were found only exceptionally in the lymphatic glands, and no bacilli were present, and with 13 cases of tuberculosis and phthisis, in which, in spite of the presence of extensive intestinal ulcers, no micro-organisms were found in the spleen or lymphatic glands. The ulceration of the intestine, here as in typhoid fever, did not favor the entrance of micro-organisms. In six of the cases of typhoid he found bacilli, generally in the glands, less often in the spleen; in 11 cases he found nothing. The average duration of the disease in the positive cases was rather longer than in previous observations. The number of bacilli was, on the whole, less; only in one early case (of 14 days' duration) was it very large. The bacilli agreed in all respects with the earlier descriptions, but were not so abundant as in Klebs' cases. In addition there were, besides the ordinary form, some long broad threads, perhaps only another phase of development.

LETZERICH (*Arch. für Exp. Path.*, Band xiv., Heft 3), having observed that the hypostatic sputa of typhoid patients contained the typhoid bacillus in great quantity, cultivated it with care in isinglass jelly. He found that rab-

bbits infected with this material by hypodermic injection sickened and died in about seven days. Dissection showed injection and swelling of the mucous membrane of the small intestine and Peyer's patches; the spleen was enlarged. In another earlier series of experiments, in which the washed micro-organisms from typhoid stools were employed, he found atrophy of the spleen. He explains, by the longer duration of those cases, atrophy succeeding to the primary state of enlargement; and he refers to the case of a rabbit placed by his children in the hutch he had used for these experiments, and which sickened and died in seven or eight weeks; on section, it showed atrophy of the spleen and numerous atrophic patches in the intestinal mucous membrane, with no Peyer's patches, but, in their place, thin transparent areas surrounded by a slightly thickened and pigmented edge. These experiments show that the typhoid poison may be introduced by other ways than the alimentary canal, and that the bacilli have the power of entering the blood-vessels and being transported with the blood-current. They leave the blood again, and pass into the tissues, either directly by diapedesis, or enter white corpuscles, which act as their carriers through the walls. Microscopical examination of the tissues of these animals showed the tissues, especially Peyer's patches, infiltrated with fungoid growth in zöoglœa-masses of a pale yellow color, probably derived from the coloring matter of the blood. Some of the spore-cells give rise to bacilli by endogenous division, which form networks for the most part,

but soon become enlarged at each end, so as to assume a dumb-bell form. This infiltration leads to necrosis of the tissues. In the spleen, similar micrococci and bacilli, forming colonies, are found in the interstitial spaces, under the capsule, and between the elements of the organ. The small veins are often blocked by the growth, causing capillary hemorrhages. In the lungs, there are inflammatory foci formed by the accumulation of lymphoid cells in the alveoli between which are micrococci and spore-cells. The veins are often obstructed by fungoid growth. In a postscript he adds that, after seeing Klebs' description of a fine thread-like form of the micro-organism, he looked over his preparations carefully, and found it present in those follicles in which the process had not reached a higher degree. These researches fully identify his earlier described "micrococcust yphiabdominalis" with the "bacillus typhosus" of Klebs.

Typho-Malaria.

Dr. PAUL L. BRICK, (*Medical Brief.*) Permit me to state in a few words my treatment of typho-malaria. To answer the question if quinine is an oxytocic, what shall we use in cases of fever. We have had this fever raging in the neighborhood for upwards of a year, and for the last six months it has proven fatal in a great many cases. I have satisfied myself that it was not the malaria but the quinine that acted as an oxytocic, and have discarded the quinine treatment on that account in pregnant females altogether, and since, I find that I obtain better results from salicylic acid, I have discarded quinine almost entirely. I give my patients five to fifteen grain doses of salicylic acid every two to four hours in connection with a little Dover's powders when needed.

In cases where tympanitis is very severe I use turpentine emulsion, yet I have resorted to that remedy only in two cases out of one hundred. I find that tympanitis is generally controlled by poultices of pulverized lini, eight ounces, and herb hyoscyami, two ounces, applied as hot as can be borne over the abdomen. To control hemorrhage or guard against it I use potass. chlorate and tinc. ferri muriat. with plenty of pure glycerine.

When I can keep my patients at perfect rest in bed and give them plenty of milk and egg-nog to drink I fear the disease but little. Of course, I use calomel or tannic acid in cases where these remedies are indicated. I always keep in my mind this fact: that there is more danger in giving too much than not enough medicine. The dry, hot flannel cloth vigorously applied to the patient controls profuse perspiration.

Sierra Salvia: A Substitute for Quinine in Fever.

Dr. A. COMSTOCK (*Ther. Gazette*) in an article on this remedy and its uses concludes as follows:

1. The advantages of Sierra Salvia are that the preparations which take their name from the "Countess del Cinchon," are certainly more objectionable in other ways than the oppressive cost: the salvia is much more palatable, and when diluted with lemon acid, as above, is not refused by children even.

2. It acts more promptly since we require from three to five hours to secure the culminating effect of quinine.

3. It is less inclined to disturb the patient's system, for it produces no ringing of the ears, no deafness, no temporary delirium (and I have taken to the extent of 10 doses in one evening to test the effects, and only found the per-

spiration and excretions of the kidney increased).

4. There is not the depression which usually follows a protracted seige with cinchona extracts, and a tendency to quiet sleep succeeds the active effect of the salvia, instead of wakefulness, which is the law with quinine.

5. It passes out of the system per the kidney in not more than 10 or 12 hours, whilst it requires from 24 to 48 hours for quinine to be become excreted.

6. Thus far I find no instances in which other remedies are incompatible.

Cedrine and Valdivine.

DUJARDIN - BEAUMETZ AND RESTREPO (*Archives Générales de Médecine*), have recently studied cedrine and valdivine, two drugs recently introduced as antipyretics. Valdivine is very toxic, and causes vomiting followed by a torpor in which the animal succumbs without convulsions. Given to hydrophobic dogs it has suppressed the convulsions, but has not prevented death. It appears to have no influence over intermittent fever. Cedrine is much less toxic than valdivine; in man it produces vertigo, and its antipyretic properties, though incontestable, are less sure and slower than sulphate of quinine. Neither cedrine nor valdivine has any action on frogs. Valdivine might, in the opinion of the therapeutical editor, prove of value in the treatment of lyssa as a means of producing euthanasia.—*Chic. Med. Review*.

Quinine Enemata.

In a lecture on the treatment of malarial fever, published in the *Detroit Lancet*, Dr. ALONZO CLARK, of New York, with regard to the methods of administration, observes:

I have not become a lover of the hy-

podermic injection of quinine, for it so very generally has made sores in instances where I have seen it used. If the druggist can prepare it in such a way that there will be no irritation, I would be less inclined to object to it; but I know it is effectually administered by injection into the bowel, and given in this manner it acts, at least, in an innocent way. But it must be given in large doses to be effective. The doses that were employed four or five years ago would seem only to inflame the fever and not to reduce the temperature. It must be used in ten grain doses, three times a day, and you will find that injecting it into the bowel will be just as efficacious as if it were taken by the mouth. The old account of the matter was that a double dose should be given when the medicine should be administered by injection. I do not think so, and I feel quite sure that I can make five or ten grains of quinine, properly dissolved, do just as much for the general system, when injected into the bowel as if it were taken into the stomach. It may not be true of a large circle of medicines, but I am confident that it is of this.—*Med. and Surg. Reporter*.

The Pathology of Malaria.

Dr. M. A. LAVERAN (*London Lancet*) has found in the blood of malarial patients very definite and remarkable parasites. They are of different shapes, some being curved, cylindrical bodies, with pointed extremities, with pigment granules in the centre, making a dark spot. Others are spherical and about the size of blood corpuscles, also containing pigment. Fine filaments could be traced on these bodies about three times the length of a red corpuscle. The first, or cylindrical corpuscle had no motion; the spherical, however, owing

to the filaments, had an oscillating movement.—*Can. Lancet.*

Intermittent Fever and Quinine Hypodermically.

In the *Lancet*, Dr. P. A. SMITH contributes the following case: A sailor, aged 32, had been sick for three months, with continuous quotidian fever and scurvy. On the day after his admission into the hospital it was deemed advisable to test the statements he had made as to his febrile condition, by allowing him to remain in bed and giving no medicine. At 8.45 A.M. he felt cold, and at 9 A.M. his temperature in the axilla was 102° F., and at 11 A.M., 104°; after which there was a gradual decrease every half hour until 1 A.M. when it was 100.4° F. He was ordered a hypodermic injection of six grains of quinine at 8 P.M., to be repeated at 8 the following morning. It was reported the next day that he passed freely and without fever through the usual times of having the paroxysms. There was no increase of temperature and no uneasiness, and he says this is the first time he has been free from fever for the past three months. He had two injections at the same hours on the two following days, when it was noticed that the arm where the injection was given was somewhat tender, and the quinine was given by the mouth, dissolved in tartaric acid, which mixture was continued in diminishing doses for the next fourteen days. He daily gained in strength, and left, three weeks after admission, in excellent spirits. No slough or abscess marked the site of the injections, and the pain experienced at the time of injection was slight and soon passed away.—*Med. and Surg. Reporter.*

Quinia Combination for Intermittents.

REED recommends the following formula in the treatment of intermittents:

R. Quinidiæ sulph., grs. xxx.; oleo-resinæ capsici, grs. iij.; morphinæ sulph., gr. j.; syrapi, q. s.

M. Ft. pill., No. x. Sig. One every three hours.

He says that if a cholagogue cathartic be given at the start, and a full opiate (preferably a hypodermic injection of morphia) an hour before the expected paroxysm, this combination has been uniformly successful in his hands, even in most obstinate cases of intermittents.

In cases of malarial cachexia he finds that many recover under the influence of sea air, without any medication. When the latter is necessary he has seen excellent results from small doses of nux vomica combined with the sixteenth of a grain of podophyllin, or one-fourth of a grain of blue pill, and repeated every four or six hours.—*Ibid.*

Malaria and Rickets.

The attempts to show a relationship between malaria and the various diseases of the body have in late years been very active. Indeed, there are few diseases now, from leprosy to diabetes, in which the particular poison of the swamps has not been thought to play more or less of a part. It is indeed suggested that if the Principle of Evil had only chosen to embody himself in the *bacillus malarie*, he would have found an immense pleasure in the exercise of his unblest activities.

This is only preliminary, however, to some account of another function that has recently been attributed to malaria, viz., that of being the cause of rickets. Oppenheimer, of Heidelberg, in the *Archiv für klinische Medicine*, has ventured to defend this view, and he presents arguments which are certainly ingenious and interesting.

The writer in question first attacks

the present views of the cause of rickets. He asserts, as others have done, that a famine diet and bad hygiene do not by any means always bring on this disease, and that too much attention has been paid to the osseous lesions, which are after all only secondary. He states that, before the bones are affected, the patients show characteristic symptoms. Such, for example, is a certain form of diarrhoea which appears on fixed days, generally in the morning, and with a periodicity generally like that of tertian ague. At the same time the abdomen becomes tumefied, and the spleen invariably enlarges. These symptoms may be absent, and the disease announce itself by other crises, also periodical. Thus the child at night has attacks in which he cries for hours, the spleen is enlarged, the temperature rises but falls again toward morning with profuse sweating of the head.

Professor Oppenheimer contends that when rickets has reached the stage of marasmus, the appearance of the patient resembles closely that of an adult with malarial marasmus. And he puts side by side the description of the two conditions as portrayed by classic authors. As regards the osseous lesions found in rickets alone, our author reasons in the following ingenious manner: The medulla of bones is undoubtedly affected in malarial poisoning of adults, as has been shown by the investigations of Arnstein, Browicz, Heuck, and others. This medulla has an equally undeniable function in the manufacture of red blood-corpuscles, and perhaps in metabolism. But such function is comparatively inactive in the adult, while it is very active in infancy and early childhood. A poison, therefore, which might have little effect upon an adult medulla would be very injurious to the bones of infants.

A final argument is drawn from the geographical distribution of rachitis. It is shown by Hirsch that this disease is extremely rare in countries where paludal fevers are unknown, as upon the elevated plateaus of Europe, and in the north of Scandinavia. — *Medical Record*.

A Remedy for Trichinosis.

Dr. J. M. BASTEN claims to have successfully treated four cases of trichinosis with large quantities of glycerine. The treatment is based upon the fact that immersion in glycerine proves fatal to the parasite. — *Gaceta Med. de Ser.*

Trichinosis.

DR. GERMAIN SEE (*Lancet*) makes four clinical types in this disease. The first is the gastro-intestinal form where choleraic symptoms are predominant. The second is the rheumatoid form, where the most marked symptoms are muscular pains. The third is the oedematous form, where unilateral or bilateral swelling of the face is the most noticeable feature. The last form is the typhoid type, which presents three distinctive symptoms, profuse sweating, facial oedema, and a brief pyrexia. This latter is the most fatal type, death occurring in the second or third week. — *Ibid.*

Leucocythæmia and Hodgkin's Disease.

DR. GRAHAM, Toronto, Canada (*Canadian Journal of Medical Sciences*), concludes about the relations of these two closely allied diseases. First: That the essential features of leucocythæmia are the lymphoid growths, and the leucocytes found in the blood derived from them. Second: That the existence of similar growths is the essential feature of Hodgkin's disease; but in it the leucocytes, for an unexplained reason, do

not enter the circulation. Third: That in both diseases the presence of these deposits or growths interferes with the manufacture of the red corpuscles, anæmia resulting. Fourth: That these growths bear a strong resemblance to those of a malignant character, especially the sarcomata. Fifth: That pernicious anæmia may arise as a consequence of leucocythæmia, or Hodgkin's disease, in the same way that it sometimes results from pregnancy or any other condition which interferes with the proper elaboration of the blood.—*Chic. Med. Review.*

Therapeutics of Anæmia.

In his Gulstonian Lectures upon Anemia, Dr. SIDNEY COPELAND showed that iron acted with great rapidity in enriching the blood with corpuscles. He has found arsenic in some instances more efficacious than iron, and as an hemantinic ranks it next to that of metal. Phosphorus has been given with benefit to a case of idiopathic anemia. Quinia, strychnia, and the mineral acids were of value as aids to iron. Manganese is a dead failure. Oxygen increases appetite and assimilation, but is not hemantinic directly. Transfusion, as a last resort, must be used in pernicious anemia before the patient is very far gone. He thought well of the use of defibrinated blood by the rectum systematically.—*Louisville Medical News.*

In Anæmia with Weakness of the Digestive Organs.

R. Ferri redacti, grs. 12-60; pepsinæ, grs. 36; zinci phosphat, grs. 18.

Glycerini sufficient to make a mass.

Divide into twenty-four pills, silver them and order two to be taken every day at dinner. *Med. Gazette.*

Prophylaxis of Smallpox.

Dr. ELLIS, after stating that he was now attending a case of smallpox, asked for the best means of preventing its communication from the patient to others with whom he came in contact.

Dr. Taneyhill spoke of the method which he had employed in 1869. He always saw the patients after meals; he talked through a handkerchief whilst in the room, and he always changed all his woolen clothes in an adjoining room before entering that occupied by the patient.—*Maryland Med. Jour.*

Smallpox Disinfectants.

From the *National Board of Health Bulletin* we note the following methods for smallpox disinfection, ordered by the Illinois State Board of Health. The best disinfectants are, sunlight, fresh air, soap and water, thorough cleanliness, for general use. For special purposes the following are the most efficient, the simplest and the cheapest:

1. *Copperas disinfectant.*—Sulphate of iron (copperas), one and one-half pounds; water, one gallon. A convenient way to prepare this is to suspend a basket containing about sixty pounds of copperas in a barrel of water. The solution should be frequently and liberally used in cellars, privies, water closets, gutters, sewers, cesspools, yards, stables, etc.
2. *Sulphur disinfectant.*—Roll sulphur (brimstone), two pounds, to a room ten feet square, and in the same proportion for larger rooms. When using this, have all windows, fireplaces, flues, keyholes, doors, and other openings, securely closed by strips or sheets of paper pasted over them. Then place on the hearth, or stove, or on bricks set in a wash tub containing an inch or so of water, an iron vessel containing live coals, upon which throw the

sulphur. All articles that cannot be burned, on account of their value, must be left in the room, while this fumigation must last for twenty-four hours, and may be repeated, when the doors and windows should be left wide open for two or three weeks. 3. *Zinc disinfectant*.—Sulphate of zinc (white vitriol), one and one-half pounds; common salt, three-quarters of a pound; water, six gallons. Into this solution all clothing, blankets, sheets, towels, etc., used about the patient should be dropped immediately after use, and should be well boiled as soon as practicable. Into this solution ought to be dipped the outer wrap of any visitor when he leaves the room. In the event of death, the body should be wrapped in a sheet thoroughly saturated with this solution. 4. *Thymol water*.—Made by adding one teaspoonful of spirits of thymol to a half gallon of water. Spirits of thymol is composed of thymol, one ounce, alcohol, 85 per cent., three ounces. This may be used for the same disinfecting purposes as carbolic acid; it is quite as efficient and has an agreeable odor. When thymol is not available, chloride of zinc solution may be used, half an ounce of chloride of zinc to one gallon of water.

Carbolic Acid in Diphtheria.

DR. Z. T. MAGILL, of Lincoln, Mo., contributes to the *Chicago Medical Journal and Examiner*, the following method of treating diphtheria, from which he has secured better results than from any other. He uses an ordinary hose, from three to five feet long and about one inch in diameter. One end is placed over the spout of a common tea kettle, into which has been put half a gallon of water and half an ounce of carbolic acid. The kettle is then placed on the stove, over a good fire,

and when the water reaches the boiling point, the free end of the hose is carried under a blanket thrown over the patient's head. The room must be closed. In a short time the patient will perspire freely. If persevered in at short intervals, breathing becomes softer, and presently, after a succession of quick expulsive efforts, the patient throws off a coat or tube of false membrane. The acid vapor seems to prevent the re-formation of exudation. Alcohol and sulphate of quinine are used in conjunction with the acid, for their supporting properties.—*Med. and Surg. Reporter*.

Treatment of Diphtheria.

In the *British Medical Journal*, Dr. H. CRIPPS LAWRENCE thus writes:

The following combination of the glycerols of tannin and carbolic acid has proved itself, during a considerable experience of diphtheria and scarlet fever, a highly efficient application in my hands, viz.:

R. Glycerini acidi tannici, 3 vij;
glycerini acidi carbol., 3 j. M.

In the application of glycerine as an absorbent, it is of practical importance that a small proportion of water should be added to it: In order to secure this, a sufficiency of glycerine should be placed in a saucer, and a throat brush dipped in water should first be stirred into the glycerine before applying it to the throat and fauces. The combination above mentioned has been found practically the most efficient proportion for securing the necessary astringent and antiseptic results, without irritation. An application, twice or at most thrice, in the twenty-four hours, secures the utmost benefit the remedy affords. It is seldom that any additional local remedies are required, but it is wise to precede the application of the glycerols

with gargling the fauces and washing out the mouth with a solution of permanganate of potash and water, and to use the sulphurous acid spray, the double advantage that follows being that the fauces are the better prepared to benefit from the glycerine, and that the safety of the practitioner is increased in the event of the patient expectorating any false membrane during the act of swabbing. To further increase the safety of the medical attendant, a glass screen placed between him and the patient will afford protection, without limiting the efficiency of the procedure.

Diphtheritic Peritonitis.

Dr. C. J. LEWIS, of Chicago, reports the following case of peritonitis from diphtheria:

The patient was ten years old, and had been ill for four days before coming under the doctor's observation. The patient was very hoarse, and there were patches of false membrane on the uvula and tonsils. There was marked albuminuria. The bowels were obstinately constipated, and the urine was voided at intervals of a day and a half. A week subsequent to coming under Dr. Lewis' observation the patient was seized by marked symptoms of peritonitis, from which she died; there was no autopsy permitted. The case is, in many respects, exceptional, but that the peritonitis resulted from an extension of the diphtheritic process there can be no doubt.—*Chicago Med. Review.*

Diphtheria.

Dr. LOLLI, of Trieste, uses exclusively the following mixture in the treatment of diphtheria, and in sixty cases the mortality was less than two per cent., the malady having a duration of but eight or ten days, and being but rarely prop-

agated to the mucous membrane of the respiratory organs:

R. Ferri sesquichlorid., gr.xv gr.xlv; ac. carbolic. pur., gr.xv-gr.xlv; Mel. rosæ, $\frac{1}{2}$ j; aquæ calcis, $\frac{1}{2}$ xv. M.

The throat is swabbed with this mixture every half hour, adults using it as a gargle, and it is, besides, to be taken in tablespoon doses, diluted every second hour. Of course tonics and very nourishing food form most important adjuncts to the treatment.

Iodoform In Diphtheria

Has been used by Dr. SESEMAN, of St. Petersburg, with favorable results. He applies a mixture of iodoform, one part; milk sugar, three parts.—*Review.*

The Treatment of Diphtheria by Papaya.

M. BOUCHUT (*Le Progrès Medical*), has found by experiment that the false membranes of croup dissolve in a few minutes in papaya juice. He has used it with success to remove the false membranes from the throat.—*Birmingham Medical Review.*

Eserine in Diphtheritic Paralysis of the Ciliary Muscles.

Dr. THEOBALD reports a case of paralysis of the ciliary muscles (paralysis of accommodation) following an attack of diphtheria in a boy. There was also loss of power in the faucial muscles, and speech was very indistinct. The ciliary paralysis was complete. He gave the patient strychnia in one-thirty-second-grain doses for a week with only slight improvement. He then in addition to the strychnia, the dose of which was gradually increased to one-sixteenth of a grain, prescribed eserine locally (two grains to the ounce of water) twice a day for three days, then once a day for two days, making five days in all of

treatment by this agent. The result was a prompt and complete restoration of accommodative power and the recovery of perfect vision, which has remained permanent. There has also been improvement in the other paralytic symptoms.—*Maryland Med. Journal.*

Pleuritic Effusion.

Notable diminution or suppression of vocal resonance and fremitus are signs justly reliable in the majority of cases in diagnosis of pleuritic effusion. It is, however, important to recognize that in rare instances they are apparently wanting. This fact is exemplified in a case reported by Dr. A. Flint (*American Journal of the Medical Sciences*), in which an exploratory puncture showed the presence of serous liquid within the right pleural cavity, with flatness on percussion over the whole right side of the chest. Over the scapula and in the infra-clavicular region, the respiration was bronchial, and there was marked bronchophony. Over the remainder of this side there was absence of respiratory murmur, but the vocal resonance and fremitus were somewhat greater than on the left side. Dr. Baccelli maintains that by means of the whispered voice the nature of the liquid within the chest may be ascertained. According to him, if the liquid be serous the whispered voice is well transmitted through the liquid, and is pectoriloquous in character. On the other hand, the voice is not well conducted if the liquid be purulent. Dr. Flint further states, that in the last case of empyema which he saw, the loud and the whispered voice were conducted over the whole of the affected side of the chest with such intensity that there had been doubt as to the presence of liquid, although the patient had been previously aspirated. At the next aspiration a very large quan-

tity of pus was withdrawn. In this case the liquid was serous, and although the vocal resonance and fremitus were but little diminished, there was no diffused conduction of whispering bronchophony or pectoriloquy observable, with delirium or stupor.—*Ibid.*

Physiological Effects of Prolonged Bathing.

In an investigation on the above subject, published in *Paris Médical*, for December, and giving a very accurate account of the effects which baths produce on the system, according to their duration and temperature, Dr. THÉRY has arrived at a number of conclusions which are both interesting and true. He says: A bath at 97° Fahrenheit is without effect on the circulation. All baths below 97° reduce the action of the heart. The beats, however, acquire greater energy. The pulse retains perfect regularity. Circulation is not reduced in direct ratio with the temperature of the water, but it is influenced by the duration of the bath.

When baths at 75° or less are prolonged for an hour, arterial pulsation continues decreasing after exit from the water. Baths at or below the temperature of the body quicken circulation. This acceleration is proportional to the temperature of the water. The pulse is irregular and the heart fluttering.

Baths between 97° and 99° are without effect on animal heat. Baths below 97° reduce the temperature of the body. Baths between 92° and 97° cause a loss of 0.97° to 1.46°; this reduction is obtained within half an hour; after this the thermometer remains stationary, even should the bath be continued for two hours.

In baths at 86° or under the fall in temperature is more gradual; it is in proportion to the duration of the bath.

The first effect of a bath at 72° or less causes a slight elevation of temperature. The fall in temperature obtained by means of a half hour bath at 93° is almost equal to that produced by a bath at 72° continued for an hour. After a bath above 82° , continued for an hour or two, temperature has an upward tendency, although for the following twelve hours it remains from 0.5° to 1° below what it was before the bath. After a bath under 81° , the thermometer continues falling during the next twenty minutes following exit. During the twelve hours following a prolonged bath, at from 64° to 81° , the thermometer indicates a reduction of 1° to 1.50° from the initial temperature.

All baths at or above the temperature of the body produce a rise in central temperature. The rise, in proportion to the temperature of the water, is progressive. A bath at 108° , continued for nineteen minutes, raises the temperature of the body to 104° . A bath at 68° progressively raised to 95° produces a fall in temperature. A bath at 97° gradually reduced to 75° causes, as a first effect, a fall in temperature; but subsequently, in proportion as the temperature of the bath decreases, that of the body rises. It is only between 91° and 97° that baths can be continued for a long time without causing suffering.

In water, the sensation of cold acts by reflex action, first on the smooth muscular fibres, and later on the striated.

Hot baths predispose to syncope; they are followed by profuse perspiration.

All baths, when long continued, are debilitating.

DISEASES OF THE NERVOUS SYSTEM.

The Treatment of Epilepsy.

Although there is much satisfaction in using a remedy alone, yet we find in many instances an advantage to be derived by the mixture of several different agents capable of producing the same effect in different ways. For example, iron and quinine, are, when combined, a more excellent tonic than either one alone. It has long been claimed that a combination of bromides make more headway against epilepsy than bromide of potassium alone. The experience of Brown Sequard was to this effect, and his formula, (take Potass. Iodid., one drachm; Potass. Bromid., one ounce; Ammon. Bromid., two-and-a-half drachms; Pot. Bicar., two scruples; Infus. Calumbæ, six ounces; Mix. — One drachm before each meal, and three drachms at bed-time—is in constant use at the present day. In the *Journal de Med. de Paris*, January 21st, 1882, Prof. Ball recommends the use of the alkaline bromides, particularly those of ammonium and sodium, with belladonna and oxide of zinc. He administers these bromides of each 10 parts in 300 of water, commencing with teaspoonful-doses four times a day, and increasing up to eight or ten doses daily, if the treatment is not followed by improvement within a few days. The belladonna and the oxide of zinc are given in pill form, 15 grains of each being made up into forty pills, and of these, two are taken daily, one in the morning and one in the evening; four pills can be given daily in rebellious cases without causing any inconvenience. For many reasons he prefers this double salt to the other bromides; it does not produce the headache or torpor generally following the prolonged use of the

bromide of potassium, and even when a cure is not produced the double bromide diminishes the frequency and intensity of the attacks, even in cases where the bromide of potassium has failed. The eruption following the use of the potassium salt is rarely seen when the double bromides are used.—*Can. Journal of Med. Sciences.*

The Eyes in Hystero-Epilepsy.

In a late communication Dr. FÉREÉ (*Louisville Medical News*) mentioned some facts concerning various phenomena observable in the eyes of hystero-epileptics. Pressure on the ovaries, he says, modifies the dimensions of the pupil materially. As a result of numerous observations he found that whenever the field of vision is permanently lessened, or when the patient is color-blind, there will also be absence of sensibility in the conjunctiva and in the cornea.

Curare in the Treatment of Epilepsy.

Prof. EDLEFSEN, of Kiel (*Journal de Thérapeutique*). The author has tried curare in a certain number of cases of inveterate epilepsy, in order to compare the results with those reached by the use of bromide of potassium and atropine.

The curare has been administered as follows: R. Curare, 50 centigrammes; aqua destill, 5 grammes; acid hydrochlor., 1 gtt.

Digest during twenty-four hours and filter.

Of this solution the author injected, every fifth day, one-third or four-tenths of a Pravaz syringe. These injections caused neither very much pain nor local inflammatory reaction. There never appeared any symptoms of intoxication.

If the favorable action of curare do not manifest itself after the fourth or fifth injection this medication must be renounced.

The following are the results gained by Edlefsen :

In two cases of hystero-epilepsy, the medication has had no effect. In thirteen cases of essential epilepsy, mostly inveterate cases, six patients were not benefitted, three were definitely cured, three others have seen their attacks much diminished in frequency and intensity; the last case was on the way to cure.—*Ther. Gazette.*

Case of Epilepsy Cured by Enucleation of the Eye.

Dr. H. ROSENCRANS, of Elgin, Ill., relates in the *Chicago Medical Journal and Examiner*, the following history : "The patient here referred to was cured of epilepsy by the enucleation of an eye. Mr. K—, of Indianola, Texas, for years past had been troubled with epileptic fits. The history given by himself to me was that about ten years ago he lost the sight of one of his eyes by taking "cold" in it. Since then he has had spells of his eye inflaming, paining him very much, and usually bringing on an epileptic fit. I advised its enucleation. I told him that it was possible, and even probable, that it might be the means of curing him of his epilepsy. He consented to its removal. On the 9th day of February last I removed it. While under the influence of chloroform, and while I was in the act of removing the eye, he was seized with a fit of epilepsy, and it took four strong men to hold him on the operating table. I kept up the chloroform, and, as soon as his fit left him, lasting about ten minutes, I at once removed the eye. With cooling and antiseptic dressing the socket soon healed. I then, as a constitu-

tional remedy, put him on the use of bromide of potassium. He has had no epileptic fit since."

Tetanus Successfully Treated by Chloral and Bromide.

Dr. J. W. SALTER (*The Practitioner*) reports a case of traumatic tetanus in a man fifty-one years of age, successfully treated with large doses of chloral and bromide, sometimes every half hour, but usually every two hours—occasionally at longer intervals. The total amount given in the twenty days' treatment was sixty drachms of chloral and eighty drachms of bromide, or three and four drachms per diem respectively.—*Can. Lancet*.

Traumatic Tetanus Treated by Sulphate of Eserine.

Dr. LAYTON, in the *New Orleans Medical and Surgical Journal* for March, reports a case of severe tetanus in a boy eleven years of age, occurring three weeks after injury to the foot. Bromides, chloral, cannabass Indica, were tried without good effect. Eserine was then substituted in doses of one-sixty-fourth of a grain (a milligramme) every hour, in the following prescription: R. Eserin, sulphat., gr. $\frac{1}{6}$; glycerin., f 3 ij.; syrup. aurant. cort., f 3 xiv.; aquæ, f 3 ij. M.

The glycerin being added to prevent change in the eserine. The full adult dose (a teaspoonful) was given at first every hour. At no time were there symptoms of poisoning by the agent, and no contraction of the pupils: in short, nothing but the beneficial effects of the remedy was manifest. The dose was gradually reduced as the symptoms ameliorated.—*Med. Times*.

On the Etiology and Treatment of Tetanus.

In a paper read before the Central Ohio Medical Association, and publish-

ed in the *Ohio Medical Journal*, Dr. J. H. POOLEY, of Columbus, gives the history of a number of cases of tetanus, following various injuries and surgical operations. Nearly all these cases presented this common characteristic, that the wound was bathed in unhealthy discharges, and the doctor believes the retention of pus in contact with the wound to be one of the most common exciting causes of this disease. He therefore enjoins cleanliness as a prophylactic measure. Under treatment he considers the free incision of wounds, amputation if there be considerable destruction of tissue, and anodyne and antiseptic dressings, for which purpose he gives preference to chloral. General treatment consists in absolute rest, the administration of calabar, which he regards as the remedy *par excellence*, to be given in full doses. Chloral and morphia he considers valuable adjuvants.

Bulbar Paralysis Cured.

Dr. HELLER, of Teplitz, reports a remarkable case of a patient suffering from, as he affirms, true bulbar or glosso-labio-pharyngeal paralysis, who was nearly cured in a few months by the daily use of baths alone. The patient had suffered for about nine months before he was put under this treatment. He could then hardly swallow at all, and could not speak intelligently. His improvement began within three weeks. The case is very carefully reported, and there seems to be no room for error in diagnosis.—*St. Petersburg Medicinesche Woch.—Med. Record*.

Neuralgia.

A writer in the *Medical and Surgical Reporter*, extols poultices made of tobacco and flax seed. It relieves pain and is much more effectual than a simple

poultice. He has used it in perityphlitis and in local neuralgia.

Tonga.

DR. EDWAR C. MANN (*Ther. Gazette*): I am happy to testify to the efficacy of tonga in an inveterate case of neuralgia appearing after sunstroke. All remedies had been tried, including hypodermics of morphia and atropia, when I happened to think of a sample of tonga sent me. I administered half a teaspoonful, and in half an hour the patient experienced a sense of general warmth diffusing itself over the body, with some slight alleviation of the excruciating pain. I administered a second dose of half a teaspoonful, when a sense of drowsiness came on, and sleep with entire relief to the pain, and the paroxysms are decreasing in frequency and are cut short in the manner I describe. I have put my patient on a constitutional treatment of cod liver oil and arsenic, with instructions to take up tonga when needed. I have used it only in this one case, but it was a typical one of great severity, and I send this report for what it is worth.

Acupuncture in Nervous and Spasmodic Affections.

The *Journal des Sciences Médicales* for December contains an interesting article on the above subject by Dr. ARENS, from which we extract as follows:—

The Doctor frankly admits that it was accidentally he at first used acupuncture, but that within the last few months it has given him most excellent results, in a number of local spasmodic affections. His first experience was with a lady, who for four months past had suffered from severe gastralgia, attended by nausea and frequent vomit-

ings; this had finally produced considerable exhaustion. Having been called to her during the night, and finding her in great suffering, all other means having failed, he proposed relief by a hypodermic injection of morphia. He had with him Pravaz' injector but the morphine solution was missing. It was then he bethought himself of acupuncture, and decided on making two subcutaneous punctures over the epigastrium, using for that purpose capillary trocars, which he left *in situ* for five minutes.

The pain diminished soon after the first puncture, and ten minutes later had entirely disappeared. It has not since then been felt, and the cure is a radical one.

Subsequently, in a case of nervous asthma, the Doctor again had recourse to acupuncture, with satisfactory results. The paroxysms were invariably checked by simply introducing the trocar of an injector two or three times under the skin, within a small space, on a line with the internal extremity of the clavicle. On several occasions, not having steel needles at hand, he made use of ordinary pins, and obtained quite as good results. This treatment was successful in over fifty instances. The attacks passed off within ten minutes, and the patient enjoyed quiet rest.

Finally, the Doctor used acupuncture with success in the case of a boy thirteen years old, troubled with an almost constant nervous cough, lasting from morning till night. Three pins applied, as in the case of the asthma patient, and left in place for half an hour, cured the cough, which has not since then again appeared.

Cases of hysterical cough have likewise been cured, and in some instances the paroxysms in whooping-cough have been greatly relieved. Hence, the Doctor concludes by recommending a

more frequent use of acupuncture, and suggesting that it may often advantageously replace hypodermic injection.

Sensory Impulses in Locomotor Ataxia.

FISCHER (*Berliner Klinische Wochenschrift*), has recently examined five cases of tabes to determine the relative rate of transmission of sensations of touch and pain. Such experiments require patients intelligent enough to give an accurate description of their feelings. The retardation of impressions of pain may be considerable. He found it once to extend to fifteen seconds. Sensations of touch may be delayed longer than those of pain. The delay may vary during the experiment; it may become less on repeating the stimulus; or, contrarywise, the stimulus may cease to be perceived at all. Retardation of other sensations (temperature, pressure, etc.) was not clearly demonstrated. The author does not offer any explanation of the retardation.

Iodide of Potassium in Frontal Headache.

The London *Medical Times and Gazette* says:

DR. HALEY states, in the *Australian Medical Journal* for August, that for some time past he has found minimum doses of iodide of potassium of great service in frontal headache. A heavy, dull headache, situated over the brow, and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food, which sometimes approaches to nausea, can be completely removed by a two-grain dose dissolved in half a wineglass of water, and this quietly sipped, the whole quantity being taken in about ten minutes. In many cases the effect of these small doses has been simply wonderful. A person who, a quarter of an hour before, was feeling

most miserable and refused all food, wishing only for quietness, would now take a good meal and resume his wonted cheerfulness. The rapidity with which the iodide acts in these cases constitutes its great advantage.

The morbid condition here described is so very common, that we would invite the experience of any gentleman who may see fit to give this remedy a trial.

Conium and Salicylic Acid in Chorea.

Dr. T. CHURTON LEEDS, England (*British Medical Journal*), claims to have had very good results from a combination of these two drugs in rheumatic chorea. The salicylic acid was given in twenty-grain doses in combination with half a drachm of succus conii in the course of every four hours.

DISEASES OF THE RESPIRATORY ORGANS.

Pneumonia and Alcoholism.

Dr. L. W. SWEETNAM (*Can. Jour. Med. Sciences*):

H. W., aged 20, had been drinking for three or four years, but heavily only at intervals during the past year. He was a tuck-pointer by trade, and lately much exposed to wet and damp. On the Saturday preceding his admission he had been on a heavy spree, and on Sunday felt greatly out of sorts. He soon developed pain in the right side and cough, and on medical advice being sought it was ascertained, he said, that he was threatened with inflammation of the right lung, which, however, the doctor hoped to avert. Instead of improving, however, he grew worse, and on Thursday he was so delirious and unruly that his mother had him removed to the hospital. He was admitted in a semi-

conscious state with pain in right side and difficulty in breathing. During the night active *delirium tremens* developed; he talked incessantly in a rambling fashion, suffered from hallucinations of sight, and could with difficulty be kept in bed. Examination of the chest on the following day revealed the physical signs of pneumonia (crepitation in some parts, tubular breathing, dullness, and increased vocal fremitus), over the greater part of the right lung; the expectoration resembled a thick bloody jelly and was copious. He was ordered:—Ammon. carb. ʒ ijss., tr. cinchon. co. ʒ j., tr. capsici. ʒ ij., syrapi, ʒ j., aquæ ad. ʒ viij. Sig. ʒ ss. o. h. 3. sum. The pulse was small, soft, and feeble, and the skin perspiring. He was allowed milk *ad libitum*, but no stimulants. On admission he had been given half-drachm dose of bromide of potash and chloral hydrate; but notwithstanding their repetition at a few hours' interval, he got no sleep for the first two or three days and then only momentary snatches, waking up as delirious as ever, so that he had to be constantly watched for five or six days and nights, but ultimately fell asleep and woke up rational. The lung symptoms remained in *statu quo* for several days, except that the sputa assumed the prune juice type, and resolution then set in and progressed with fair rapidity. An attack of diarrhœa came on which proved rebellious to the ward mixture (catechu, paregoric and lime water) for a couple of days, but was soon controlled by the following:—℞. Argenti nitratis gr. xvj.; acidi nitrici diluti ʒ iij.; tincturæ opii deodoratæ, ʒ ij; tincturæ cardamomi compositæ, ʒ j; mucilaginis acaciæ ad, ʒ viij; misce. Sig: ʒ ss., exaqua o. h. 4, sumat. Convalescence was speedily established and he went out on January 18th cured.

Acute Pneumonia in India.

According to Surgeon DEAKY (*India Med. Gazette*), pneumonia frequently occurs among the natives of India of an asthenic and latent type and is particularly intractable to treatment. He has been led to employ belladonna in such cases, and has had good results from its use. He attaches much importance to the regular action of the bowels during administration of the belladonna, and gives magnesium sulphate in addition to potassium bromide or iodide. The combination of iron with belladonna also tends to induce a proper action of the bowels. If there is much muco-purulent expectoration, it is advisable to give an ipecacuanha emetic before commencing the belladonna treatment.—*Chic. Med. Review.*

Clinical Treatment of Pneumonia.

Dr. PICOT, Professor of Medicine of the Faculty of Bordeaux: The expectant treatment is recommended by Boerhaave, Pinel, Louis, Magendie, Skoda, Diete. While it is true that pneumonia pursues a regular course, with a tendency to restoration to health, yet nature must be assisted. The experiments of Grisolle show that pneumonia, well nursed, often recovers without medicine, produces skepticism in medical treatment, alike injurious to patient and physician.

The old treatment of Broussais and Bouilliard, by copious bleeding, has been set aside and phlebotomy is the exceptional practice. M. Peter has lately tried to restore blood letting as the principal treatment. The temperature and pulse are both lowered, but only temporarily. The author reviews the antiphlogistic treatment. Moderate bleeding may be allowed in young healthy persons, but in old people,

pregnant females, the alcoholic, the diabetic, and in any persons with broken down constitutions, and in children particularly, the lancet must not be used. Death threatens by dyspnoea and asphyxia. Local scarifications are often useful. The latter treatment, which depresses the heart, must be rejected absolutely.

To Dr. Hirts, of Strasbourg, is the honor of giving digitalis in pneumonia. As a tonic to the action of the heart, digitalis answers well. It also abates the fever, and is antipyretic, but in large doses may become as injurious as tartar emetic. It is necessary to watch its effects.

The use of alcohol and quinine produced a revolution in the treatment of pneumonia. It is to Rood he gives the credit of using alcohol to sustain the patient during the evolution of his pneumonia, and particularly when the disease is located in the upper portion of the lungs, as in old and debilitated persons. In these cases alcohol and quinine become the leading drugs in this disease.

Revulsives are employed, particularly when there is much hepatization. He thus presents his summary: No tartar emetic, no blood letting, except in robust persons, and in cases threatened with asphyxia. At the beginning, digitalis and scarifications; later, alcohol and quinine, and in feeble subjects these from the beginning, and often digitalis with them. At the close of the disease, a blister if necessary.—*Journal de Therapeutique.*

DISEASES OF THE CIRCULATING ORGANS.

A Curious Case of Venous Dilatation.

LINDNER (*Cbl. f. Chir.*, from *Deutsche Zeitscher. f. Chir.*) gives the case of a

man 42 years of age, of a family in which many members had died of apoplexy, and who during the previous two or three months had suffered from a somewhat swollen face, rush of blood to the head, ringing in the right ear, giddiness on stooping, and severe burning in the face. Some days after the first examination, marked cyanosis of the face was observed, particularly on the right side. The veins of the chest were also markedly enlarged and swollen; on the anterior border of the axilla was a convoluted mass of varicose veins; in the right supraclavicular fossa was a tumor the size of a hen's egg, from the upper border of which proceeded the enlarged jugular vein. Pressure upon this non-pulsatile tumor caused it to disappear, the patient experiencing at the same time a marked rushing sound in the ear. The tumor, which could be pushed deep down into the chest, rose again on the removal of pressure. On the left side a similar tumor could be perceived about one-half the size of that just described.

Examination of the heart showed nothing abnormal, and the various other organs seemed to work well. Daily subcutaneous injections of ergot caused the tumors to rapidly disappear. They became flatter and harder, while the subjective symptoms disappeared at the same time. Since a central hindrance to circulation could be excluded, Lindner is inclined to regard the affection as a chronic phlebitis localizing itself in the neighborhood of the valves. The venous walls were so altered thereby that they gave way to the moderate pressure caused by the slight obstruction in the affected valves.

MEDICINE.

CONSTITUTIONAL DISEASES.

The Differential Diagnosis of Typhoid Fever and Tubercular Meningitis.

Dr. LAMBERT OTT (*Med. Times*): My attention has been called to this subject, at the bedside, by often noticing what a similarity of symptoms existed in the diseases in question in the incipient and more advanced stages. I, with other physicians, have left the bedside of a child presenting symptoms pointing to either disease, in which it was impossible to make a positive diagnosis. In both there are irritability, headache, vomiting, diarrhoea or constipation, loss of flesh, anorexia, and evidences of constitutional disturbances. In the incipient stage, when the child shows this array of symptoms, the physician meets with great difficulty in coming to a definite conclusion. Where the diseases are more advanced—the case of tubercular meningitis being in a stupor and that of typhoid fever in a somnolent state—our judgment is oftentimes taxed to decide. From full notes of a number of cases of typhoid fever and tubercular meningitis, ranging in age from 11 months to 8 years, I have formulated the following differential diagnosis:

INCIPIENT STAGE.

Tubercular Meningitis.

There is a gradual loss of flesh, extending over some weeks or months.

Irritability more intense and prolonged; restless during sleep.

Shunning light is common.

Temperature has no characteristic change; may be high in the morning and low in the evening, or the same morning and evening.

Vomiting causeless, and not connected with ingesta. May find a clean tongue.

Headache not aggravated at any particular time of the day.

Nearly always constipation.

No abdominal tenderness.

Pulse of good volume, moderately slow, and occasionally irregular.

No epistaxis.

Typhoid Fever.

Loss of flesh only apparent after fever-process has existed some time.

Irritability not so intense; quieter during sleep.

Absent.

Typical fever-curve; gradual ascent, having low fever in the morning and higher in the evening.

Vomiting nearly always connected with curdled milk or repugnant medicine. Coated tongue.

Headache always aggravated, towards evening, when the fever ascends.

Diarrhoea, as a rule; exceptionally, constipation.

Abdominal tenderness and tympanitis.

Pulse soft, rapid, and never irregular.

Often epistaxis.

ADVANCED STAGE.

Tubercular Meningitis.

Irregular temperature curve or no fever at all.

Now the vomiting generally ceases.

Stupor is continual, patient not easily aroused, and immediately falls back again into his former state.

Obstinate constipation.

Retraction of abdomen.

Tache cérébrale; sudden and spontaneous blushing of cheek, and of parts exposed to pressure.

Cheyne-Stokes breathing.

Pulse very irregular.

Spleen normal.

Local palsies and local spasms; fixedness of the eyes; unequal or dilated pupil.

Extreme tenderness elicited on pressing the femur.

Urohematin, but no albumen or indican in the urine. (Robin.)

One symptom—that of distress elicited by pressure on the femur—is an incidental discovery of mine, and came to my notice in the following manner: While examining a case of tubercular meningitis in the stage of stupor, I was desirous of awakening the patient for the purpose of witnessing the mental phenomena. To accomplish this, I surrounded the thigh with my hand and squeezed it moderately hard, which caused the child to utter a piercing scream. As this seemed out of all proportion to the amount of injury inflicted, I repeated the pressure in a less degree, and the same outcry was provoked. Seizing other parts of the extremities with the same amount of force caused no disturbance whatever. I repeated the experiment in a second case, and found a similar manifestation, while pressure on other parts produced no such effect.

Albumen Water in Typhoid Fever.

Albumen water is recommended as a good substitute for milk and beef-tea, in cases where these substances disagreed with the patient, or could not be obtained. The preparation is largely used by the French. It is made by dissolving the white of one or more eggs in a pint

Typhoid Fever.

Continued fever, stationary, or ascending gradually with the morning remission.

May have vomiting of ingesta.

Is easily aroused; remains awake for a time and requests drink. Is usually rational during the time of being awake.

Generally diarrhoea, yellow or brownish stools.

Tympanitis and tender abdomen.

Roseolar eruption.

Breathing at times very irregular, quite sighing, but not the rhythmical irregularity. One day regular and the next very irregular.

Pulse weak and regular.

Spleen enlarged and tender.

No such manifestations.

No tenderness on pressure.

Indican and albumen always present in the urine. (Robin.)

or two of water, sweetening with glycerine, and flavoring with orange-flower water. It may be taken cold and used *ad libitum*. It is an excellent food in typhoid fever and typhoid dysentery.—*Dublin Jour. of Med. Science.—Med. News.*

Carbolic Acid in Typhoid Fever.

Dr. RAMONET following out the results already claimed by Desplats, Dèclat and Van Oye, as to the use of carbolic acid in typhoid fever, comes to the following conclusions (*Archives Gènèrales de Mèdecine*, May, 1882): Carbolic acid does not only act as an antipyretic in typhoid fever, but it also exercises especially on this fever a curative antizymotic action. The dose of carbolic acid given by washing the external surface should not exceed sixty grains per diem. Doses greater than this are liable to be followed by dangerous secondary and immediate effects. The treatment by carbolic acid may be followed by serious pulmonary complications or by carbolic acid intoxication. Convalescence is the period in which these are especially to be dreaded. This treatment with carbolic acid, Ramonet claims, yields the best results in typhoid fever, but it should always be supplemented by tonics and cold baths, with the latter especially, it can with very great advantage be combined at times.—*Chic. Med. Review*.

Sudorific Treatment of Typhoid Fever.

Mr. RICHARD RYDER praises highly (*British Medical Journal*) the sudorific treatment of typhoid fever, which he has employed for twelve years. He takes incipient cases, and keeps up a continual sweating for eight or ten hours. This is repeated as often as the temperature rises very high. He sweats his patients by covering them with blankets and a macintosh sheet.—*Med. Record*.

Resorcine versus Quinine in Malarial Affections.

STILLÉ's experiences with resorcine in the treatment of intermittent fever have not been very satisfactory. Of

thirteen cases in which this drug was administered, in five the result was favorable, in six it was only palliative; while in the two remaining no effect at all was noticed. These last two classes were, however, promptly cured by quinine. The smallest dose of resorcine was 0.3 gramme, given to a boy of three years, without benefit; the largest dose was four grammes, also without the slightest favorable influence. The average dose should be about twice as large as that of quinine. (The administration of resorcine in quantities greater than three grammes has produced alarming symptoms, although Stillé states that nothing of a serious character was observed in his cases.)—*Betz's Memorabilien*.—*Ibid*.

Malaria and Dental Hæmorrhage.

Dr. GUENARD (*Journal de Mèdecine de Bordeaux*), after a somewhat extended examination of cases of hæmorrhage coming on after the extraction of teeth, comes to the following conclusions respecting this: Among the numerous causes of internal origin which lead to and keep up hæmorrhage after the extraction of teeth, should be included malarial infection, either recent or old. In certain cases where there are no obvious symptoms present of malarial infection, quinine sulphate will yield very good results. In conjunction with ordinary hæmostatic methods and those particularly adapted to dental hæmorrhage, quinine sulphate should always, in obstinate cases, be administered.

Intermittent Fever Caused by Flower Pots.

The practice of keeping plants in rooms the temperature of which is maintained at a high degree, says Prof. CRUDELLI, "is often disastrous to the health." Furnished as the flower pots are, with earth rich in organic matter,

the greatest facility is given to the malarial germs to proliferate. Altogether non-favorable opportunities for the development of malaria can scarcely be conceived. Crudelli cites the characteristic case of Mr. V. Eichnald: The latter had under his care a Russian lady, who lived in a healthy climate where malaria was not common. This patient suffered from characteristic attacks of malarial fever which yielded readily to large doses of quinia. But the relapse supervened with remarkable and almost inexplicable frequency. Hardly had this patient recovered sufficiently to return to the dining room where the flowers overcame her as forcibly as ever. The presence of a large number of plants in the room finally attracted the attention of the physician. When they were re-

moved the fever disappeared permanently.—*Lyon Médicale*.—*Cin. Lancet and Clinic*.

Treatment of Vomiting in Phthisis—Papaya-juice in Croup.

Dr. BROOKES D. BAKER, Government Physician at S. Kona Hawaii, Sandwich Islands, writes: "I have found by experience that the vomiting in phthisis can be controlled, in some thoroughly, in others partially, by the ether spray on the back of the neck, doing it just before meals. In very bad cases I have used it on the stomach as well.

"In cases of croup and diphtheria, the juice from the green fruit of the papaya breaks up the membrane, so that it comes away quite freely."—*Med. Record*.

Acute Miliary Tuberculosis, Intermittent Fever, Pneumonitis and Typhoid Fever.

Dr. C. R. CRANDALL (*Med. and Surg. Reporter*), makes the following differential points.

Acute Miliary Tuberculosis.

1. Chills occur at irregular periods.
2. Fever remittent in character, and not influenced by treatment.
3. Pulse rapid and weak, with tendency to increase.
4. Temperature constantly elevated, with variations between 100 and 103.
5. Marked disturbances of respiration.

Acute Miliary Tuberculosis.

1. Onset gradual.
2. Chills frequent and more or less persistent.
3. Temperature runs up gradually, never extremely high, subject to remissions.
4. Irregular sweats are a common symptom.
5. Pulse rapid and weak from the first.
6. Cyanosis and lividity a prominent symptom, but most marked during the later stages.

Intermittent Fever.

1. Chills occur periodically.
2. Fever intermits and yields to treatment.
3. Pulse rapid and full during fever, and then subsides.
4. Temperature characterized by extreme changes.
5. No disturbance of respiration, as a rule.

Pneumonitis.

1. Onset rapid.
2. Usually one severe chill followed by more or less chilly sensations.
3. Temperature rises very rapidly to about 104, continues high for a few days and then begins to decline.
4. Sweating is more or less frequent, and continuous in some cases.
5. Pulse rapid, but full and strong during first stages.
6. Cyanosis or flushing a common symptom early in the disease.

7. Rapid breathing a marked symptom.

8. No soreness or pain in the lung.

9. As a rule, no dullness on percussion.

10. Crepitant or coarse bronchial râles may or may not be present at first, but frequently appear during the later stages of the disease.

11. More or less cough and expectoration generally present.

Acute Military Tuberculosis.

1. Onset gradual.

2. Frequent chills.

3. Possibly more or less headache.

4. Mental disturbance and delirium not the rule, but may occur.

5. No epistaxis.

6. Tongue usually dry and coated.

7. Bowels may or may not be normal.

8. No abdominal tenderness or tympany.

9. Temperature rises gradually, and there may be evening exacerbations and morning declines.

10. Râles are generally present sooner or later.

11. Breathing soon becomes rapid and so continues.

12. Pulse rapid and weak.

13. Generally either marked cyanosis or lividity is a common symptom.

14. More or less profuse sweats a common symptom.

15. No eruption.

16. Subsultus tendinum may exist.

7. Rapid and shallow breathing a marked symptom.

8. Usually more or less pain.

9. Dullness sooner or later over a portion of one or both lungs.

10. Crepitant and sub-crepitant râles; mucous and submucous râles in the larger tubes, appearing within the first 24 or 48 hours.

11. Cough a marked symptom. Expectoration becomes abundant, sputa often discolored.

Typhoid Fever.

1. Onset gradual.

2. Usually a chill followed by chilly sensations.

3. Headache generally complained of.

4. Mental disturbance and delirium a common symptom.

5. Epistaxis a common symptom.

6. Tongue dry and coated.

7. Bowels generally loose. Exceptionally, constipation may exist.

8. Abdominal tenderness and tympany.

9. Temperature rises gradually, and generally has a regular evening exacerbation and morning decline.

10. Râles are frequently present, sooner or later.

11. Breathing but slightly, if any changed, unless complication supervenes.

12. Pulse rapid and weak.

13. Cyanosis not often present.

14. More or less sweating in about half the cases; in the other half the skin is hot and dry.

15. Eruption may appear after seventh day.

16. Subsultus tendinum may exist.

The Phosphates in Phthisis.

M. DUJARDIN-BEAUMETZ, in his clinical lessons on practical therapeutics, remarks that though the phosphates cannot be considered as specifics in phthisis, still they often prove useful in improving general nutrition.

He recommends the following mixture:—℞. Sodii phosphate, ℥ iss; potass, phosphat., ℥ j; syr. aurantii cort., ℥ ij; vini (claret), ℥ vij. M.

A wineglassful of this mixture may be taken after each meal.

This preparation gives excellent results, particularly when there is constipation and the quinine preparations are not well supported.—*Ibid.*

Pulmonary Consumption—Recovery.

Dr. FRANCIS MINOTT reports seven cases of pulmonary consumption in which recovery took place, in the *Boston Medical and Surgical Journal*. The first case was that of a hackman, aged 30. He presented undoubted evidence of phthisis. He was placed on the use of cod-liver oil, with croton oil to the chest, externally. Two years subsequently no trace of the disease could be found.

The second was in a lady, aged 35, whose mother had died of consumption. She was given the same treatment and improved rapidly. When examined, four years from her first sickness, the physical signs of phthisis were all wanting, and her strength, color and flesh were perfectly good. She subsequently died, ten years after her first sickness, of consumption, which first made itself manifest only six months before death.

The other cases were treated much in the same way, and the results were equally satisfactory. In one case the influence of hygiene in checking the

ravages of consumption was most marked. The patient was a young man of means. His left lung was sufficiently disorganized to allow of a perceptible depression of the chest wall on that side. He was ordered Churchill's hypophosphites, whisky, cold sponge bathing, and iodine to chest. He possessed the means to travel, to ride, and to lead that healthy life so particularly necessary for one whose lungs are weak. He recovered entirely, so that in three years' time he weighed one hundred and fifty-three pounds, and seemed perfectly well. He now imagined he had heart-disease, and became hypochondriacal, and finally died suddenly, while in a railroad train, after complaining a few minutes of faintness. No autopsy was made. These cases teach us that we need not despair when confronted with a case of consumption of the lungs; but they also indicate, that while cod-liver oil and other such tonic and sustaining remedies will do some good, we must look for the greatest benefit from hygienic surroundings. Therefore, unfortunately, is it that pulmonary consumption is a disease so fatal among the poorer classes, while those in affluent circumstances can provide the means wherewith to check its progress.

The Treatment of Acute Rheumatism.

The treatment of simple acute articular rheumatism may be abandoned to rest and nature. Apart from complications, such cases nearly always recover under rest and careful nursing. Try and disabuse yourselves of the idea that their cure is dependent upon medicines alone; to help nature is often the best we can do. No treatment was ever invented which stopped a case of acute articular rheumatism. It cannot be stopped by bleeding or sweating, or purging, by nitre, by tartar emetic, by guaiacum, by alkalies, by salines, by sa-

licylic acid, or by anything else. The physician can palliate the pain and perhaps shorten the attack, can control and perhaps prevent complications and stiffness of the joints, but he cannot arrest the disease. Where rest, proper diet, and warmth are enjoined, most cases will get well just as soon without as with the use of medicinal methods. Purgatives have been used in all ages in the treatment of this disease, because it was thought to be a fever. We are all but too ready to put our necks into the yoke of a theory. In old times they thought that the system ought to be reduced. Before the time of purgatives depletion was employed. This mode of treatment I will not even discuss. There is no evidence of which I am cognizant in favor of purgatives. There are very good reasons, indeed, why they should not be used: (1). Because they cannot possibly cure; (2) because they oblige the patient to make painful movements; and (3) because they expose him to the dangers of cold. There are certain cases in which purgatives are alleged to be of use, viz: those in which the bowels are constipated, and there is a bitter taste in the mouth. I have never seen such cases except in habitual drunkards, and in such patients a purgative does more harm than allowing the effete matter to remain in the system. Opium was once vaunted as a specific, and it was claimed that it diminished the tendency to complications in the course of the disease. More recent experience has shown that opium, of all remedies, is the most likely to cause heart complications. Some have recommended colchicum, arguing that because it does good in gout, it must, therefore, do good in rheumatism. But colchicum is not a remedy for rheumatism. Many years ago it was very much the custom to administer large doses of powdered Peru-

vian bark. The rationale of these large doses was founded upon their sedative effect. Never was there a more profligate waste of a precious medicine. I believe that it has also been fashionable in the so-called cases of hyperpyrexia to immerse the patient in a bath varying in temperature from sixty to ninety degrees. Although patients thus treated sometimes recovered, they also sometimes perished from congestion of the lungs and brain.

Among cardiac and nervous sedatives, digitalis, veratrum album and viride, veratria and aconite, have each, at one time or other, been employed indiscriminately. Such treatment, of course, has only proven itself to be a monument of rashness to those who employed it.

Within the last few years new remedies have been proclaimed in the shape of salicylic acid and its sodium salt. I confess that I possess no personal knowledge of their use in this disease, for I was at first dissuaded from employing them by a prejudice against the grounds on which they were recommended, and more recently by the contradictory judgments respecting them, and the unquestionable mischief they have sometimes caused.

It may be difficult to see the connection between blisters and alkalies in their power to influence the course of acute articular rheumatism, and yet it is certain that they do so influence it, and in the same way, *i. e.* by altering the condition of the blood from acid to alkaline. If you ask me to explain to you how blisters act in this way, I am obliged to confess my ignorance. To produce this result they must be applied over all the affected joints. Experience, if not science, has decided conclusively in their favor. They do effect a cessation of the local symptoms, render the

urine alkaline, and diminish the amount of fibrine in the blood.

This brings us to a consideration of the use of alkalies. Alkalies neutralize the acids, act as diuretics and eliminate the *materies morbi*. Alone, and in small doses, they are unable to influence the course of the disease; but when given in very large doses their effects are marvelous; the pulse falls, the urine is increased in quantity and becomes alkaline, and the inflammation subsides. The symptoms of the disease are moderated, the duration of the attack is shortened, and the cardiac complications are prevented. The dose of the alkalies must not be increased until the acid secretions are neutralized. A very good combination of these remedies is the following:

R. Sodæ bicarb., 3 iss.; potassæ. acet., 3 ss.; acid. cit., f. 3 ss.; aquæ, f. 3 ij.

S.—This dose should be repeated every three or four hours, until the urine becomes alkaline. On the subsidence of the active symptoms two grains of quinine may be added, with advantage, to each dose. The alkalies must be gradually discontinued, but the quinia continued. The diet should consist of beef tea or broth, with bread and milk; no solid food should be allowed. Woolen cloths moistened with alkaline solutions may, with advantage, be applied to the affected joints. To these laudanum may be added for its anodyne effect. The patient must be sedulously protected from vicissitudes of the temperature, and be in bed between blankets. The alkaline treatment relieves the pain, obates the fever, and saves the heart by lessening the amount of fibrine in the blood. A long time ago Dr. Owen Rees, of London, introduced the use of lemon juice. This remedy was thought to convert uric acid into urea, and to so help

elimination. Though this treatment is practically correct, the theory of it is all wrong. Lemon juice does good in mild cases, but cannot be relied upon in severe attacks. During the fibrile stage of acute articular rheumatism the diet should consist mainly of farinaceous and mucilaginous preparations, with lemonade and carbonic acid water as drinks. The cloths applied to the joints should be changed when they become saturated with sweat, and in changing them the patient should be protected from the air. The sweating may be controlled by small doses of atropia, from the one-sixtieth to the one-twentieth of a grain. To prevent subsequent stiffness, the joints should be bathed with warm oil and chloroform, and wrapped in flannel cloths. In the proper season the condition is very well treated by sea bathing. There is no specific plan of treatment in acute articular rheumatism. The treatment pursued must vary according to the intensity of the inflammation and the peculiarities of the patients.—ALFRED STILLE, M. D., in *Med. Gazette*.

Blister Treatment of Acute Rheumatism.

Dr. HERBERT DAVIES, in pointing out the unsatisfactory results of the salicylate treatment (*Lancet*), claims the following advantages for the blister treatment, deduced from the observation of fifty cases at the London Hospital:—

1. Blisters well and early applied (while fever is high and pain most acute) around every inflamed joint, and followed by large poultices to favor the discharge of large quantities of serum, produce rapid and full alleviation of the pain, reduce the pyrexia quickly, and speedily restore the use of the painful joints.

2. The bold and free application of

blisters around each inflamed joint restrains the tendency of the rheumatic virus to desert the limbs for the heart, thus depriving this disease of its most dreaded result. In the London Hosp. Clin. Report, I find the following statement: "In no case where the heart was sound at admission did any organic lesion subsequently develop itself, and in two cases in which soft but distinct mitral murmur was audible when the patient came under treatment, every trace of the sound rapidly disappeared as soon as a free and abundant serous discharge had been established."

3. Relapses are slight in intensity and by no means frequent.

4. The urine loses under this treatment its abnormal acidity without the internal use of any alkaline remedy, becoming often neutral and even alkaline.

5. The time of the stay of the patients in the hospital was much less than six weeks—the old traditional remedy for acute rheumatism. The average of my cases was twenty-six days.—*Maryland Med. Jour.*

Salicylic Acid—Acute Rheumatism.

THOS. R. THORNTON, M. D. (*Medical Brief*), calls for the best vehicle for salicylic acid. The following formula will not disappoint him:—*R.* Salicylic acid, 4 drachms; potass. acet., 4 drachms; glycerine, 2 ounces; aquæ pura, 2 ounces. *M. Sig.*: One or two teaspoonfuls in a wineglass of water, every four to eight hours.

This, with a little care in combining, makes a clear and palatable solution.

In acute rheumatism, I give it, varying the dose to suit the age, etc., of the patient, every four hours, until pain and swelling are relieved. Then continue three times a day until patient is convalescent. I, at the same time, see that the secretions are acting properly, and

that the alimentary canal is clear. Severe cases are usually relieved of pain in thirty-six to forty-eight hours, and convalescent within a week.

The Treatment of Diphtheria.

H. CRIPPS LAWRENCE, L.R.C.P., LOND., ETC. The following combination of the glycerols of tannin and carbolic acid has proved itself, during a considerable experience of diphtheria and scarlet fever, a highly efficient application in my hands, viz: *R.* Glycerini acidi tannici, 3 vij; glycerini acidi carbol., 3 j. *Misc.* In the application of glycerine as an absorbent, it is of practical importance (as pointed out some time since in the *Pharmaceutical Journal*) that a small proportion of water should be added to it. In order to secure this, a sufficiency of the glycerine should be placed in a saucer, and a throat brush dipped in water should first be stirred into the glycerine before applying it to the tonsils and fauces.

The combination above mentioned has been found practically the most efficient proportion for securing the necessary astringent and antiseptic results, without irritation. An application twice, or at most thrice, in the twenty-four hours secures the utmost benefit the remedy affords—a matter of importance both to the patient and practitioner, as the former is not fatigued by frequent applications, and the latter can make these personally at the usual visits.

It is seldom that any additional local remedies are required, but it is wise to precede the application of the glycerols with gargling the fauces and washing out the mouth with a solution of permanganate of potass and water, and to use the sulphurous acid spray; the double advantage which follows being, that the fauces are the better prepared to benefit from the glycerine, and that the safety

of the practitioner is increased in the event of the patient expectorating any false membrane during the act of swabbing. To further increase the safety of the medical attendant a glass screen, placed between him and the patient, will afford protection without limiting the efficiency of the procedure.—*British Medical Journal*.—*Can. Jour. Med. Science*.

Diphtheria.

Dr. H. U. BURR (*Med. and Surg. Reporter*) gives the following case in point. The case was as follows: I was called in consultation with Dr. Hoffmeister; found the patient, a boy of fourteen years, suffering the same as I had, only much weaker, and nearly black in the face from suffocation. I advised the use of stimulants internally, and the following gargle: R. Potassa chloratis, $\frac{3}{4}$ ss.; alcohol, aqua rosæ, aa $\frac{3}{4}$ ij. M. To be used frequently.

Immediate improvement followed. Since that time I have used the alcohol very freely in diphtheritic cases, and always with the most favorable results.

Albertis on the Difference between Diphtheritic and Inflammatory False Membrane.

Dr. ALBERTIS (*Bollet. delle Scienze Mediche, Gaz. Méd. de Paris*), by treating non-diphtheritic false membrane with sulphuric acid, has obtained crystals which are insoluble in ether and absolute alcohol, but soluble in alkalis, and which he considers to be crystals of tyrosine. He has not obtained these crystals when subjecting diphtheritic membranes to the same treatment. He draws the following conclusions. Diphtheritic false membranes have a different chemical composition from that of inflammatory false membranes. Diphthe-

ritic membranes do not contain aromatic constituents like tyrosine. The action exerted by sulphuric acid and microscopical examination suffice, therefore, he maintains, to establish the nature of a false membrane.—*London Medical Record*.

Pepsin in Diphtheria.

Dr. EDWIN ROSENTHAL, acting on the suggestion of Dr. L. Wolff, has used an acidulated concentrated solution of pepsin, as an application to the membranes of diphtheritic patients, for which there seemed to be no other help than tracheotomy, and reports that it acted like a charm, dissolving the membranes, admitting of free aëration of the blood, and placing them soon on the road to convalescence. The solution he used was: R. Jensen's pepsin, $\frac{3}{4}$ j.; acidi hydrochloric, C. P., gtt. xx.; aquæ q. s. ft. fl $\frac{3}{4}$ j.

M. S. Apply copiously every hour with a throat mop.—*Med. Bulletin*.

DISEASES OF THE NERVOUS SYSTEM.

The Private Care of the Insane.

Dr. RALPH L. PARSONS (*Alienist and Neurologist*) concludes an able paper condensed as follows:

1. That public institutions have hitherto been, and for an indefinite period in the future are likely to be, inadequate for the care of all the insane who need to be removed from their own homes.
2. That public asylums, on account of necessary economies, their great size, overcrowding and other causes, cannot become the best establishments for the care and treatment of all the insane.
3. That the smaller the number of insane patients associated together, in one establishment, the better it is for the patients.

4. That the greater the ratio of sane persons associated with and in care of the insane, the better it is for the latter.

5. That chartered asylums, private institutions and private homes, each afford peculiar advantages for the care of the insane which cannot be afforded in public asylums; and, hence, that they supply a social need.

6. That the treatment of many, if not of a majority of the insane in an ordinary private house, is feasible; and that in suitable cases this method of care and treatment, under family influences and associations, and apart from the associations and restraints necessarily incidental to institutions, has special advantages for the patient not otherwise attainable.

7. That many indigent insane persons who have hitherto been confined in public institutions, might be satisfactorily cared for in private families in their own social sphere; and that judicious attempts to accomplish this object are advisable.

8. That whenever more than one insane patient is under care and treatment in the same house and family, a competent physician should be the head of the family and in responsible charge.

9. That every insane person who is not in immediate charge of his own relatives, at least, should be subject to state supervision, and should be under the professional care of a competent physician.

10. That while certain recent cases of insanity ought to be treated at their homes for at least a period of time, and while certain chronic cases may advantageously remain at home permanently, it is for the best interest of the majority of insane patients and their relatives, that provision be made for their care and treatment elsewhere.—*Det. Clinic.*

Arsenical Treatment of Chorea.

M. SIREDEY, we read in the *Revue de Thérap. Méd. et Chirurg.*, has long had recourse to arsenic in the treatment of rheumatismal chorea, and has had good results from this medication. He uses the solution of Bondin:

℞. Ac. arsenious, gr. xv.; aquæ destill., Oij. M.

This is allowed to boil for about a quarter of an hour, and is then ready for use. The extreme dilution of the solution is favorable for its use among children. For a child from six to ten years of age, about one drachm and a half may be given daily, in divided doses, in sweetened water. In this way the medicament is generally well tolerated.

Dr. Sottmann, of the Breslau Clinic, constantly prescribes the following solution in chorea:

℞. Liquor Fowleré, ℥iv.; aquæ, 3 ij. M.

This quantity to be taken in divided doses daily. He generally obtains a complete cure in from sixteen to twenty-one days.

In some cases he adds from 8 to 15 grains of chloral to the prescription. He has generally found that anæmic children, and those of hereditary nervous dispositions, bear this form of medication well.—*Ibid.*

Salicylic Treatment of Chorea.

Dr. L. S. ABBOTT (*Boston Medical and Surgical Journal*) relates a case of rheumatic chorea, treated successfully in fifteen days by salicylate of soda. The patient was a housemaid, aged 25, who had been recently in the hospital with acute rheumatism. The improvement noticed while taking the medicine disappeared during its temporary withdrawal, while rapid convalescence fol-

lowed its resumption. The dose given was at first ten grains every two hours, afterwards it was given every three hours, and finally salicin in the same dose was substituted. Dr. Abbott refers to a similar case reported by B. F. Gary, of South Carolina, and quoted in the *New York Medical Record*.—*Birmingham Medical Review*.

Spontaneous Falling of the Nails in Locomotor Ataxia.

Prof. A. PITRES, of Bordeaux, reports (*Le Progrès Médical*) two cases of locomotor ataxia, attended by spontaneous and intermittent falling of the nails of the great toes. Several weeks before the falling of the nails there was dull pain in the extremity of the affected toes, but there was neither suppuration nor ulceration of the matrix. The fallen nails were rapidly replaced by newly-formed normal ones. No injury had been inflicted upon the nails. Prof. Pitres believes that the phenomenon in question is referable to deranged nutrition of the matrix dependent upon the medullary lesions attending *tabes dorsalis*.

Incontinence of Urine as a Pre-ataxic Sign of Locomotor Ataxia.

DR. WILLIAM A. HAMMOND, (*New Eng. Med. Monthly*.) The signs of the existence of this pre-ataxic stage are thus given by Dr. Dowse:

Inequality of the pupils; small pupils; paresis of left third nerve; cutaneous fulgurating pains; sexual excitement; transitory incoördination of the lower limbs; variable patellar tendon reflex rarely absent; spinal irritability; dyæsthesia, anæsthesia, hyperæsthesia—very transitory; visual color changes; gastric and intestinal crises; temperament variable; retinal changes; mental depression; insomnia.

In the present brief paper I desire to call attention to another symptom—incontinence of urine—which not infrequently precedes any other sign of the approach of locomotor ataxia and is present for weeks, months or perhaps even years before the slightest defect in coördination is apparent.

It is not intended to imply that incontinence of urine, unaccompanied by other evidences of spinal disease, is always to be regarded as the precursor of locomotor ataxia. I am only desirous of pointing out that the symptom in question, occurring without obvious cause in an otherwise healthy person, should excite us to watchfulness and prompt to such treatment as is proper for the disease, of which it may be the forerunner.

As an example of the point to which I refer, the following details of a case, some time ago under my professional charge, will not be uninteresting.

M. J., a gentleman aged about thirty-five years, and residing in an adjoining State, consulted me for incontinence of urine. He had been affected for several months and had been treated on various hypotheses.

Having satisfied myself that there was neither prostatic disease nor a stone, I perceived that there was a condition present that allowed the urine to pass involuntarily and that that was paralysis of the vesical sphincter. The bladder itself did not appear to be involved but as soon as an ounce or so of urine accumulated in the viscus, it was discharged notwithstanding all the effort of the patient to prevent the occurrence. The contractility was not entirely lost, for a very small quantity of urine could be retained, but as soon as it passed the limit, relaxation at once took place.

There was no pain and no other indication of irritability of the neck of the

bladder. It was a sphincter-paralysis pure and simple. In all other respects the health of the patient was excellent. Upon thorough examination I could discover no evidence of paralysis in any other part of the body. There was no incoördination. The patient could stand with the eyes shut as well as any other person, and could walk in the dark without difficulty. The patellar tendon reflex was normal on both sides. There had never been any fulgurant pains nor any sensations of numbness in any part of the body.

I could not conceive the probability of the existence of a central lesion of so limited an extent as to involve only that part of the cord from which are derived the nerve fibres that go to the sphincter of the bladder, and yet there was a bare possibility of such being actually the case. I was more disposed to regard the disorder as one of eccentric origin and consisting in a lesion of the nerves of the sphincter. I advised the direct application of the faradaic current and the internal use of belladonna.

The patient being unable to remain in the city for treatment, returned to his home with a letter from me to his physician. In this communication I gave my view of the case both as regarded diagnosis and therapeutics. But in the meantime a surgeon of some local repute was consulted and on making an examination of the patient, he was convinced that the case was one of enlarged prostate. The patient was accordingly placed under his care, but after treatment had been continued without effect for a month it was decided to abandon the idea of hypertrophied prostate and to carry out the measures I had recommended.

But now it was found that a new complication had arisen. What were regarded as "neuralgic pains" in the

lower extremities were causing a great deal of suffering, so it was determined to send the patient to me for a second examination. As soon as he mentioned the character of the pains in his legs my suspicions were, of course, aroused. I ascertained that they had been giving trouble for about two weeks. They were the sharp electric-like pains so characteristic of locomotor ataxia. Upon asking the patient to stand and shut the eyes I found that he could not comply without staggering, and that upon attempting to walk with the eyes shut he wobbled greatly. On examining now I found the patellar tendon-reflex almost entirely abolished on both sides. The case was one of fully-developed locomotor ataxia.

I treated the patient with large doses of ergot and belladonna and with cauterizations over the lumbar and spinal regions. In a few days the tone of the sphincter began to show signs of improvement and in the course of two weeks the paralysis was so far relieved that the bladder could contain six ounces of urine without the necessity for passing it being very urgent. This amendment still continues, though there has been a steady advance in all the other symptoms of locomotor ataxia.

I am thoroughly convinced that had the real nature of the bladder affection been ascertained in the very beginning of its existence, the further development of the morbid process in the cord would have been prevented.

DISEASES OF THE RESPIRATORY ORGANS.

Treatment of Pertussis.

M. DUJARDIN-BEAUMETZ, in his recently published *Leçons de Clinique Thérapeutique*, recommends the bromides with chloral in the treatment of whooping cough.

He gives, morning and evening, in a glass of milk containing a yolk of one egg, a desert or tablespoonful (according to the age of the child) of the following mixture:

R. Potass. bromid., 3 ss.; sodii bromid., 3 j.; ammonii bromid., 3 ss.; syrup. chloral. (Fr. cod.), 3 iss.; aquæ, 3 ij. M.—*Med. and Surg. Reporter.*

The Treatment of Whooping Cough.

In the *Allgemeine Med. Cent.-Zeitung*, Dr. ELBEN says that he has treated whooping cough in a great many ways. He has tried inhalations of tannin, quinine internally, and insufflations of quinine and bicarbonate of soda. He then returned to belladonna, chloral and morphine. In particularly serious cases, in which children were in danger from want of sleep, or owing to vomiting of all food, he has exhibited morphia in bold doses with excellent results; great prudence should, of course, be observed in using this remedy, and the first symptoms of intoxication must be carefully watched. In some instances bromide of potassium brought relief, but in others it was of no avail.

In three cases Dr. Elben has had occasion to try oxalate of cerium, as recommended by Morgé. To his surprise, he observed such marked progressive improvement, especially in patients suffering from severe attacks of cough and vomiting, that he was induced to suspend all other medication.

In one case he discontinued the cerium and replaced it by morphia; then, finally, all remedies were withheld. In each instance the disease became aggravated, thus warranting the belief that the remedy possessed specific qualities. For children one to seven years old, the dose of powdered oxalate of cerium is from 0.3 to 0.18 gm. (grs. 0.45-2.70),

to be taken at one time, and while fasting; later in the evening another similar dose is to be given.—*Ibid.*

Treatment of Whooping Cough.

Prof. HEUBNER has tested the comparative action of five of the most common remedies in this disease—viz., bromide of potassium, quinine, hydrate of chloral, salicylic acid, and belladonna. The bromide was given in doses of seven to forty-five grains per diem in aqueous solution, in twenty-three cases; chloral in ten cases; quinine powders up to five grains per diem in eleven cases; salicylic acid in a one-third to one-half per cent. solution as inhalations with Siegle's spray-producer, about an ounce being used at a time, in seventeen cases; and belladonna in doses of one-fourth to one grain per diem in eight cases. In none of the twenty-three cases in which the bromide was given was the duration of the disease lessened, but in nine cases the number and severity of the paroxysms was lessened. The quinine was given partly in solution and partly in powder in eleven cases, in three of which the duration of the disease, and in two the length of the paroxysms, were lessened. Chloral was given in divided doses in two, and as enema in eight cases. In two the duration of the disease was lessened, and the intensity and length of the paroxysms in six cases. Salicylic acid was given by inhalation in sixteen cases, and as salicylate of soda internally in one case. In two the duration of the disease, and in ten the length and severity of the paroxysms, were lessened. Belladonna was given in eight cases. In three the duration of the disease, and in one case the intensity of the paroxysms, were lessened. Thus salicylic acid and chloral tend to relieve the paroxysms; bella-

donna and quinine to shorten the disease. — *Fahrh. f. Kinderk. ; London Pract.*

Urine of Acute Pneumonia.

At a recent meeting of the Medical Society of the College of Physicians (Dublin *Journal Medical Science*), Dr. WALTER SMITH made a communication relative to a peculiarity observed in the urine of a patient suffering from acute pneumonia. A young gentleman, aged 22, not previously very robust, caught cold. He was seized with rigors, headache, and vomiting, and the temperature ran up to 105°. He complained of intense pain over præ-cordial region. On the fifth day the physical signs were detected, of early consolidation, in the base of the left lung. The other lung became involved, and the young man died without ever rallying. Some of the urine passed on the fifth and sixth days was examined. That of the fifth was very turbid with lithates; that of the sixth was nearly clear. Each specimen examined was bright colored and acid; chlorides markedly deficient.

1. Serum albumen.—Tested by the usual methods, a very moderate amount could be precipitated; no distinct floculi.

2. Serum globulin.—Saturation of the urine with sulphate of magnesium threw down an abundant precipitate of globulin.

3. The urine, freed from albumen, yielded an opaque white precipitate with tannic acid, and also with phosphotungstic acid, and it was rendered turbid by alcohol. The tannic precipitate dissolved by heat, and was re-precipitated on cooling. These reactions suggested the presence of peptone; but, since the urine, when freed from mucus (by acetate of lead), and albumen (by precipitation along with basis acetate of iron),

yielded no color with Millon's test, and failed to give the xantio-proteid reaction, the presence of any albuminoid seems to be negatived. Moreover, all attempts to get the characteristic biuret reaction for peptone ended in failure. The patient had been treated with sulphate of quinia, but direct testing of the urine for that alkaloid gave a negative result. This case elicited some discussion, but without any conclusion as to the nature of the precipitate.

The chairman (J. W. Moore, M. D.) remarked that the outcome of the case, from a clinical standpoint, was that it afforded another proof that pneumonia is an essential, continued fever, manifesting itself, in connection with the lungs, only after a lapse of a certain period of invasion. In fact, the lesion of the lungs was analogous to the condition of the intestines in typhoid fever, or to the condition of the skin in the exanthemata or eruptive fevers.—*Med. and Surg. Rep.*

Iodide of Potassium in Pneumonia.

In the *Moniteur Therapeutique* we read that M. RIEBE has tested clinically this medicament, which M. Schwartz considers capable of arresting the progress of pneumonia. M. Riebe used this medication exclusively in thirty-seven cases of pneumonia. In twelve cases there was double pneumonia, and in three others the disease was complicated with pleurisy.

In some cases he was able to commence treatment during the first twenty-four hours, administering every second hour a tablespoonful of the following solution:—℞. Potass. iodid., ʒ jss, 6.00 Gm.; Aquæ, ʒ vij, 240.00 fl.Gm.

A bladder containing ice was placed over the region of the thorax, corresponding to the affected portion of the

lung. Of the thirty-seven patients treated, but one succumbed, and in this case the pneumonia was double. M. Schwartz in ten per cent. of his twenty-eight cases succeeded in arresting the malady after the second day.

The results obtained by M. Riebe, although less brilliant, are satisfactory, and should lead to the further employment of a remedy which is at least innocuous in its action.

The preceding year M. Riebe, simply followed the expectant method in twenty-two cases of pneumonia in young, healthy soldiers, and found that generally the malady was of longer duration than when treated by iodide of potassium.—*Medical and Surgical Reporter*.

Grindelia Robusta in Asthma.

The *grindelia robusta*, an *asteroidea* growing on the slopes of the west coast of America, which is used in those regions as the safest remedy against asthma, has of late attracted the attention of physicians in an increased degree. In favor of this new remedial plant with reference to the therapeutic effects, it is claimed that the plant is not numbered among the narcotics, as the *solaneas* (*hyoscyamus*, *stramonium*, etc.), which have been used heretofore, but that it comes from a family which altogether furnishes us "*hervica*." The *grindelia robusta* is, according to experience, the most effective species. The resin is an essential part of its effectiveness.

Quantities of this resin, taken in proportion to the quantity of tobacco used, were employed to impregnate well nitred tobacco, and from this cigarettes were formed, which, after long observations during several months, have always satisfactorily benefitted those asthmatics which have used them. The use of

these cigarettes, which are easily lit, and either smoked, or the smoke of which is fanned towards the patient, is recommended by the author for every patient, even for non-smokers (ladies), as the cigarette once lit, on account of the quantity of saltpeter with which it is impregnated, will continue to glow and develop smoke.—Von Bombelon (Bergen auf Rügen), *Deutsche Med. Wochenschrift*.—*Ther. Gazette*.

DISEASES OF THE CIRCULATING ORGANS.

Mitral Presystolic Cardiac Murmurs.

From a careful clinical study of the varieties, mechanism, and clinical significance of mitral presystolic murmurs, in the *American Journal of Medical Sciences*, Prof. AUSTIN FLINT draws the following conclusions:—

1. There are two varieties of this murmur, which are distinguished by differences in quality and in mechanism. One variety is a rough, and the other is a soft, murmur.
2. The roughness in the first of these varieties is characteristic, and may be distinguished as vibratory or blubbery. The softness of the second variety is bellows-like, like other soft cardiac murmurs. It may vary in pitch and intensity, but as a rule, it is low and weak.
3. The rough murmur is due to vibrations of the curtains of the mitral valve, caused by the passage of blood from the auricle to the ventricle. The soft murmur, like other bellows murmurs, may be due either to contraction of the orifice through which the blood passes, or to roughness of the surface over which it flows.

MEDICINE.

CONSTITUTIONAL DISEASES.

Sulphurous Acid in Typhoid Fever.

Dr. BURNEY YEO, in the June number of the *Practitioner*, gives an account of certain experiments made with sulphurous acid in typhoid fever. Three cases are cited, but the first was of too mild a type to prove any good effect from the drug, and in the second the remedy was discontinued because of alarming hemorrhage from the bowels before any effect was noted. In the third case the remedy was first used on the fourth day of the fever, the dose being one half dram of the acid every four hours. During the first five days of treatment the temperature ranged between 102° and 104° F. On the ninth day the evening temperature was 103.6° , but on the tenth day there was a notable fall. From this on to the twelfth day it did not rise above 102° . On the thirteenth day the temperature fell to 101.2° , and for the next six days it reached on one occasion only as high a point as 101° . During this time the patient seemed to be doing well, except that he was always nervous and depressed. There had been no abdominal tenderness or distension, and but five actions from the bowels during nine days. On the nineteenth day, however, he complained of abdominal pain. The temperature began to rise, reaching 103.8° on the twenty-second day, and upon the twenty-eighth day it was 104.2° . Diarrhœa and hemorrhage became persistent, and he died with symptoms of perforation on the twenty-ninth day. The post-mortem examina-

tion revealed abdominal lesions of great gravity.

Dr. Yeo concludes that while the remedy exerted no influence over the intestinal lesion, it certainly seems to have modified in a remarkable manner the temperature-curve of the fever, just as quinine in large doses is often found to do. It is worthy of note that in this case, notwithstanding the extent and gravity of the intestinal ulceration, the temperature was never very high, only twice reaching 104° .

The Treatment of Typhoid Fever in the past Four Years.

A review of the literature covering the subject of typhoid fever since 1878 is communicated to Schmidt's *Jahrbucher* by Dr. Arthur Geissler. It is interesting to note that a very large proportion of this literature is devoted to the subject of etiology and prophylaxis. Too much, indeed, is said to permit of any adequate criticism of it here. The subject of therapeutics of the disease occupies a much less space. Indeed, considering the extensive prevalence of the disease, and the mortality therefrom (four per 100,000 inhabitants in German cities), the question as to how it is best to be dealt with by the physician has received surprisingly little attention. In the articles that have been contributed we find that the measures recommended may be classed under three heads—the antipyretic treatment, the antiseptic treatment, and miscellaneous methods. The antipyretic treatment still excites the most discussion. In Germany it means the use of baths, of quinine, and

of salicylic acid. In this country other means of cooling the body than baths are resorted to, the most frequent being probably sponge-bathing. It is noticeable that there is very little literature regarding the efficacy of baths, and Geissler states that in German hospitals the mortality from typhoid fever has considerably increased since eight years ago. In 1877 it was 12.8 per cent. among 10,901 cases; in 1878 it was 13.5 per cent. among 12,406. In the years 1879-81 the figures are still more unfavorable. In Dresden, between the years 1850 and 1870, before the antipyretic treatment was introduced, the mortality was 12.6 per cent. among 3,387.

Those authors who have written recently upon this subject continue for the most part still to recommend it, but not with the exaggerated praise heard eight years ago. A. Vogel had a mortality of one in seventy cases treated with baths; Morf speaks guardedly regarding their employment; Hensch and Asby all caution against frequent cold baths for children; Keulich is enthusiastic over wet-packs combined with systematic high feeding; Steffin was only moderately successful with wet-packs; Zenetti advocates Ziemssen's treatment with calomel, baths, and quinine. One finds little said about the antipyretic value of quinine. There has been a tendency to substitute salicylic acid for it, but the results obtained seem discouraging. Of five authors who report their experience only one advocates its use. The drug in large doses reduces temperature, but its action is temporary, and is likely to weaken the heart and disturb digestion. Hallopeau and a few others think that by alternating salicylic acid with quinine better results are obtained. A survey of the recent literature collected by Geissler upon the antipyretic treatment of typhoid fever leads

to the impression that the roseate views once entertained for it are not being justified. Certainly no American statistics have been collected which show positively that the treatment by baths or by large doses of quinine has any real influence upon the mortality in American typhoid. The measure seems to be helpful in some cases. That is all that can be said.

We referred some time ago to the antiseptic treatment of typhoid fever advocated by Roth. Dr. B. Bell claims good results from a similar method, in which he uses eucalyptus. But the antiseptic treatment, as a special remedial method, has as yet no solid basis. The "water-diet" treatment strenuously advocated by Dr. Luton, of Rheims, has a curious interest only. He gives his patients only cold water, but this in large quantity, for the first four or eight days. In this way he "washes out" all the disease-germs from the bowels and the blood. Whether he cures his patients may be considered doubtful. The medical profession cannot be said to have yet formulated a treatment for enteric fever which receives any unanimous adoption. This is not to our credit, for it is very largely due to the fact that we do not work as a body, and our individual experiences are not therefore utilized.—*N. Y. Med. Record.*

Typhoid Fever and Diphtheria.

ANDREW KEY asserts that there are very strong connections between these two diseases. He relates a case where an outbreak of diphtheria was traced to contamination of water from sewage, which in the same location had been the source of seven outbreaks of typhoid fever in twenty years. During the latter part of the epidemic he had occasion to treat diphtheria and typhoid fever in the same house. He cites another case

where diphtheria, terminating fatally in three instances, was directly traced to contamination of cistern-water by sewer-gas from an untrapped overflow pipe. Several other similar instances are given. Dr. Key notes the further resemblance in this, that the two diseases are essentially confined to childhood and the prime of life, and that they are both apt to be most fatal in the middle and upper classes of society. He holds that neither disease is infectious, as are scarlet fever, small pox, &c., but both are due to water contaminated with excreta, and that by proper attention to water supply and drainage these diseases may be kept out of our families.—*Edinb. Med. Jour.*

Quinine as an Anti-Pyretic in Typhoid Fever.

Dr. BOYD CORNICK (*Med. Herald*), concludes an interesting article on the above subject, as follows:

The most satisfactory results in my hands, from quinine in typhoid fever, have been obtained from giving it in one large dose, at bed-time. Or, if the patient be very weak and nervous, give the desired quantity in two doses, half an hour apart. Begin with not less than 20 grains for an adult, and if the temperature next morning be not reduced below 101°, give 30 grains the next night. Good authority recommends still larger doses, if necessary, and I would certainly not hesitate to use them if indicated. But heretofore, 20 to 30 grains at one dose, given at bed-time, have accomplished all in my hands that I have desired or attempted in the reduction of temperature. I am satisfied that cases do occur where even the largest recommended doses have little or no benefit. But such cases are exceptions; and I do not take the utopian view of any remedy, in any disease—that it is infallible.

In a typical case, the rise in temperature, after reduction, will be so gradual that forty-eight hours may intervene between doses. Occasionally, however, it will be well to administer a large dose on several successive evenings until the temperature is well under control, and then the antipyretic doses may be omitted altogether, or resorted to at intervals, according to indications. Typical cases occur, not infrequently, of a mild character, in which, from beginning to end, there is no occasion to make use of any antipyretic measures whatever.

The salt of quinia, which my observation has led me to prefer over all others, is the bisulphate, which, from its solubility, would seem preferable, on theoretical grounds, to the simple sulphate. Experience confirms the theory. I give it in capsules, not desiring to nauseate the already irritable stomach with a bitter and acid solution. If desired, a little lemonade or mineral acid drink may be given immediately after the capsules, but I do not insist upon it.

In conclusion, I think that observation will demonstrate that, in nine-tenths of the cases typically severe at the onset of the fever, if quinia be thus administered, not only will the temperature be fully controlled and held in check, but that the muttering delirium, the picking at the bedclothes, the coma vigil, the tympanitic abdomen, will be, if not entirely averted, at least greatly and most favorably modified.

Contagium Vivum Malarie.

The *Lancet*, in discussing the various causative agents of malaria that have been brought forward by different investigators during the past few years, says that Cuboni and Marchiafava have brought forward some valuable investigations on the blood of patients suffering from the disease. They constantly

found spherical, mobile micro-organisms, in variable number, and always in the interior of the white corpuscles. At the commencement of a febrile paroxysm small bacilli were seen,* bearing a spore at each end. During the progress of the attack these bacilli lessened in numbers, while free spores became more abundant. Richard has found the parasite described some months ago by Laveran to be invariably present in the blood of patients suffering from malaria, and has never seen it in the blood of patients suffering from other diseases. The organism has a special habitat, the red corpuscles of the blood, in which it develops, and which it leaves when it has arrived at a perfect stage of development. In several of his preparations Richard has actually seen the organism escape from the corpuscle, which remained attached to it on one side, as an extremely delicate circle. In other cases the mobile filaments alone pierced the capsule, within which the body of the organism remained enclosed. Richard suggests that the comatose condition sometimes observed during attacks of endemic fever may be due to the obstruction of cerebral capillaries by masses of these special organisms.—*Med. and Surg. Reporter.*

Hydrobromic Acid.

Dr. W. E. MOIR says, in the *Lancet*, that he has obtained some excellent results from the use of this acid. A young lady complaining of severe and frequent headaches, accompanied with flushing of the face, and at times with ringing in the ears, was encountered. She seemed perfectly healthy, and there was no appreciable cause for this condition. She was ordered fifteen minims of the acid, thrice daily, after meals, in a little sweetened water. This treatment was con-

tinued for three weeks (the dose being increased first to twenty and subsequently to twenty-five minims). The happiest possible results ensued, and complete relief was afforded. Given in combination with quinine, he has found it to mitigate or entirely prevent the headache which often accompanies the use of that drug. In a case of persistent toothache, occurring during pregnancy, he obtained very satisfactory results from the use of this acid.—*Ibid.*

Hæmorrhages from Quinine.

Dr. KURIAZIDES (*Galenos, New York Med. Journal*), reports two cases in which the use of quinine was followed by hæmorrhage, in one case of renal, in the other of nasal origin. Dr. Kuriazides resorts to a somewhat far fetched hypothesis to account for these cases, which although not frequent are far from being of very exceptional occurrence.—*Chicago Med. Review.*

Alcohol; its Therapeutical Uses Internally and Externally.

A paper by Dr. BARTHOLOW, in *Medical Times*, Philadelphia, contains many interesting points. As a *stomachic* it is useful only in cases of those *not* habituated to its use; it should be given *well* diluted and *before* meals to stimulate digestion in quantities short of the strength necessary to precipitate the pepsin. In wasting diseases—chronic suppuration and phthisis—more will be required and will be better borne than in other chronic depressing maladies. In these diseases the best results are obtained from half an ounce to an ounce of whiskey taken during or immediately after meals. A teaspoonful of brandy will sometimes check obstinate vomiting when not depending on an inflammatory condition of the stomach. In vomiting of uræmic intoxication and of yellow fever a dry

champagne may be successful. Simple diarrhœa may be checked by brandy. In cholera infantum brandy is the most generally efficient agent. The Dr. has given a teaspoonful every three hours to a child under one year; it should be given in warm water and *not in milk*, as remote from the time of taking food as possible. Alcohol is very useful in chronic dyspepsia of the sedentary and weak digestion of the convalescent, in the latter a spirit is to be preferred to a wine. An acid Rhine wine of high percentage of alcohol is useful if an excess of acid is present due to fermentation. Danger of the alcoholic habit is prevented in the convalescent of a depressed and nervous patient. It is a cardiac and arterial stimulant; shortens the diastolic interval. The cardiac ganglia stimulated by the oxidation force generated, increases the rate of the heart's movement. This is true of *small* doses, but large doses have the opposite effect. In chloroform or ether narcosis, the injection of brandy, or whisky, *subcutaneously*, to stimulate the respiratory or cardiac centres, is highly improper, indeed, it contributes to a fatal result. Alcohol in large doses depresses the temperature. It may be employed as an antipyretic in acute inflammations and fevers, also as a support to the circulation and to aid the digestive function, using for antipyretic purposes large and in the other case small doses. It does good when the tongue becomes moist. The stomach can receive and digest more when the pulse declines in rapidity, and gains in force; when the surface grows moist and cool, when delirium ceases and intelligence replaces stupor, alcohol is antiseptic and useful in septic maladies; it must be given in *large doses*.

External Uses.—Its power to coagulate albumen, to suspend the activity of un-

organized ferments, and to destroy minute organisms, render it useful externally. It is a powerful hemostatic. As an antiseptic dressing to wounds to prevent entrance of the germs of putrefaction, to check suppuration and promote healing, it is scarcely inferior to carbolic acid. It is an efficient means for procuring local refrigeration of an inflamed joint or swelling. It has an anodyne power, when injected subcutaneously, which may be utilized in cases of myalgia and lumbago. Enlarged tonsils, hypertrophied thyroid, and glandular swellings may be slowly reduced often and made to disappear by the parenchymatous injection of alcohol.

Diphtheria—Sudden Death in Convalescence.

Dr. W. H. JOHNSON, of Selma, Ala., sends us the history of a patient, aged seven, suffering from diphtheria. The child was treated with a mixture of tinct. ferri muriat., ℥ viij., and potas. chlorat., gr. iv., in glycerine and water, every two hours, night and day. The nostrils were washed out with a solution of boracic acid and hyposulphite of soda. The throat was touched three times daily with a mixture of tannic acid and tincture of iron in glycerine. Abundant food and stimulants were given. At the end of the seventh day, evidences of great improvement had appeared and convalescence was nearly established. Suddenly, after having had a large movement from the bowels, the patient turned on her side and in a moment was dead.

Dr. Johnson makes the following remarks:

"Until the last morning I had but little, if any, doubt of the ultimate recovery of my patient. The swelling in the neck had disappeared and only a

small deposit was left in her throat, and she was taking plenty of nourishment up to twelve or fourteen hours preceding her death. The only symptom that gave me any anxiety, after the vomiting ceased, was the rapid fall in the pulse. At 6 P. M., on 15th, pulse was 117; and on the morning of 16th, at 8 A. M., pulse was 84, and all other symptoms favorable, and I considered that also favorable. The same afternoon, at 6 P. M., it was 70, and still no other symptoms to account for this rapid and steady fall in the pulse. The volume was good, and fair strength to the beat. On the morning of the 17th, pulse was 48, but she had been vomiting most of the night; at such a time I expect to find a frequent and feeble pulse. This pulse reminded me very much of one that had been reduced by giving veratrum. Could the chlorate of potash in the doses given have slowed her pulse? Never in any other case has it so acted with me.

"I have no doubt this child had diphtheria two days before treatment was commenced. I knew of no cases in town, and did not examine her throat.

"I have almost, if not altogether, absolute faith in the iron and potash treatment *when commenced within twenty-four hours from the onset of the disease, and when the patient will take the medicine and nourishment day and night, and as given above.* I have treated many of these patients before, and never had one die under this treatment, when seen during the first twenty-four hours. I know there are many mild cases that will get well under almost any kind of treatment. But even in this case the swelling in the neck (the anterior surface of the neck was nearly on a level with her chin) had disappeared, and the deposit had all gone but a slight patch. The nose had become clear. I am

satisfied this was due alone to the iron and potash.

"I did not at any time examine her urine. The kidneys acted throughout the disease and her mind was clear. Fifteen minutes before death she asked for milk and drank it. She was not permitted to raise herself when her bowels acted the last time, and she died without a struggle. Her attendants stated everything seemed to be going on well up to the time of the movement of her bowels. Had I been sent for during the night I should have given stimulant and nutrient enemata, and put nothing in the stomach. I saw her in the morning, noon, and evening throughout the disease. Twenty-four hours before her death I had no doubt in my own mind of her recovery. I thought the immediate cause of death was paralysis of the heart."

DISEASES OF THE NERVOUS SYSTEM.

Amyl Nitrite in Tetanus.

Dr. G. H. W. Ross reports the case of a sailor admitted to the Royal Infirmary, Glasgow, Scotland, suffering from traumatic tetanus, supervening upon an injury received in a drunken brawl three weeks previous. The symptoms first occurred in the morning, and at evening the tetanic convulsions were almost constant. Soothing applications were made to the wound, which was red and angry. A cathartic was administered. The tincture of calabar bean was given in 20 drop doses every three hours, for fifteen hours, without any effect in diminishing their frequency or severity. Nitrite of amyl was then tried in eight drop doses by inhalation at the commencement of the paroxysms. These were almost instantly aborted, and rapidly diminished in severity until they ceased entirely. Dr. Ross raises the

question whether the known power of amyl nitrite to cause a determination of blood to the brain, taken in connection with its effective action in the control of tetanic symptoms, may not throw some light upon the true causation of the disease.—*Mich. Med. News.*

Nitrite of Sodium in Epilepsy.

In the *Practitioner*, Dr. W. T. Law relates one case in which the nitrite of sodium proved so beneficial that it would seem well to record it, in order that the drug may have a more extensive trial in this terrible and hitherto intractable malady. The case was a typical one of epilepsy, occurring in a man aged twenty-nine, of a low order of intelligence, of unexceptional habits as regards drink and morals. The seizures commenced after a prolonged season of excessive study in endeavoring to prepare for a college examination. The appended table gives the result of the various forms of treatment tried:—

| Weeks. | Seasons. | Number of Fits. | | Total. | Remedies Used. |
|--------|--------------------|-----------------|--------|--------|--------------------------------------------|
| | | Day. | Night. | | |
| 14½ | Summer. | — | 28 | 28 | Brom. of pot. sod. and am. |
| 4½ | Winter. | 2 | 7 | 9 | Borax. |
| 23 | Winter and Spring. | 11 | 15 | 26 | Bromides with intervals of iron and aloes. |
| 22 | Summer. | 3 | 12 | 15 | Bromides with bellad. |
| 14 | Winter. | 2 | 1 | 3 | Nitrite of sodium. |

The Uses of Nitrate of Silver.

Dr. CHAS. K. MILLS, speaking of nitrate of silver (*Philadelphia Medical Times*), said that in nervous disorders he had found it one of the most useful remedies. In posterior spinal sclerosis, it ranked next to iodide of potassium. In chorea he had given it also with ap-

parent success; and sometimes it seemed to be of use in sclerosis of the lateral columns. In epilepsy it was not so good as the bromides, or as the zinc salts with belladonna.—*Med. Record.*

For Severe Periodic Headache.

℞. Dextro-quinia, 3 jss.; morphia sulph., gr. j. M. ft. pil. No. xvj. Sig. Take one after each meal.

Or,—

℞. Dextro-quinia, 3 iss; morphia sulph., gr. j.; acid hydrochlor. dil., q. s.; elix. glycyrrhizæ, aquæ rosæ, aa f ʒ ij.

M. Sig. Dessertspoonful after each meal three times daily.

"Either of the above affords, in my hands, prompt relief, where quinine in similar doses fails."—*Monthly Rev. of Med. and Pharmacy.*

Substitute for Quinine in Neuralgic Affections Assuming a Periodic Character, as well as in Intermittent and Remittent Fevers.

℞. Beberia sulphat., grs. 30; acid. sulph. aromatici, min. 40; syr. aurantii, ʒ i.; aquæ aurant. flor. ad., ʒ 8. M. Sig. One-sixth part three times a day.

Neuralgia.

Dr. REGINALD G. ALEXANDER, writing in the *Lancet*, makes the statement that it is now a well established fact that neuralgia is a disease arising from debility, and since it is very often mistaken for rheumatism, gout, spinal irritation, etc., he gives the following diagnostic points by which it can be differentiated: 1. Neuralgia occurs when general debility exists, is increased by fatigue, mental or bodily, but is relieved by food, and sometimes by stimulants. 2. The pain, which is sudden, darting and excruciating, exhibits remarkable intermissions, especially in the early stages of the complaint, and the con-

stitutional disturbance is slight (temp., pulse, etc., frequently normal). 3. It is usually unilateral. 4. As the disease advances, tender spots are formed in the course of the affected nerves.

Realizing that debility plays so important a part in this disease, he says, as would be supposed, that the treatment must be directed in every case toward improving the general health. Pure air night and day, great cleanliness and sponging with sea salt and water.

Hypodermic injections of morphia give immediate relief and are really curative, since by allaying pain they allow the tonic measures to be carried out.

DISEASES OF THE RESPIRATORY ORGANS.

Naso-pharyngeal Catarrh.

Dr. J. W. MOORE (*Med. Annals*), says: Rhinitis is an inflammation of the mucous membrane of the nose and vault of the pharynx, either acute or chronic, and includes all diseases of the nasal passages attended with discharge. The laryngoscope, of comparatively recent use, has given a great addition to the means of treating these parts; the use of this instrument for superior exploration, for which we are indebted to Czermak, is equally valuable. The circular mirrors are preferred for this, unless the tonsils are very large, when the oval are more convenient. If necessary these may be excised or lessened by use, locally, of iodine. Elongated uvula, another obstacle, can be overcome by amputation or by the hook or loop. Sensitiveness of the parts can be controlled by applying tannin and glycerine or a spray of a saturated solution of bromide of potassium.

Rhinitis usually presents in a sub-acute or chronic form. It is the sequence of repeated acute attacks, usually

following exposure to cold. Smoking causes it, and a perfectly healthy nose and pharynx are hard to find in a habitual smoker. Increased secretion is the well-known prominent symptoms though it may be wanting. The mirror shows the membrane congested and covered with inherent secretions. The swelling may be so great as to close the septum. The color is, instead of the normal pink, a fiery red. Ulceration may exist. All may have the disease; the scrofulous are especially liable to it.

The treatment has been until recently unscientific and unsatisfactory. Stimulating powders or solutions have been given to snuff up; consideration of the anatomy will show their uselessness. The Schneiderian membrane extends over irregular sinuses, and if spread out would cover several square inches, and the narrow meatuses are easily occluded by inflammation of this vascular membrane. Insufflation reaches those parts only where there is least inflammation, not the upper and back part of the fossæ, usually most affected, whence the morbid secretion proceeds. The general indications, are, first, to cleanse the parts and remove the adherent secretions; and, second, to restore the normal action by appropriate applications. The first is secured by the posterior nasal syringe or the spray from a compressed air apparatus, using tepid solutions of chlorate or permanganate of potash or carbolic acid used once or twice a day. Dilatation of the passages with bent metallic sounds is of great service, where strictures exist and prevent free passage of the spray. Applications may be made to the parts by means of cotton wound on a metallic sound, and may consist of equal parts of tincture of iodine and glycerine; to the posterior nares and surface of the velum palati, with a posterior nasal sponge-

holder, a solution of iodine one grain, iodide of potassium and carbolic acid, each two grains, glycerine two ounces. These may be made two or three times a week, until the discharge is materially lessened. Permanganate of potash is not only cleansing, but somewhat astringent, and is specially applicable to cases attended with profuse and offensive discharge. Of a ten grain solution, a drachm to half a pint of water may be used. Chlorate of potash, given internally, has specific action on the throat, and is a valuable adjuvant. During treatment night air must be avoided, also smoking and stimulating drinks. In more chronic cases stronger astringents, such as nitrate of silver, sulphate of copper and zinc, tannin or alum may be used. These are all good and bad according to the way they are used. Undiluted tincture of iodine or the solid nitrate of silver may be touched to circumscribed spots, as to spots of ulceration, with benefit. Weak solutions, as of two to four grains, may be used with the atomizer, but with caution, for they will often cause pain for several hours. Ulcers are often found on the posterior surface of the velum, and these give rise to very offensive discharge. They are often syphilitic or scrofulous, and call for internal treatment with iodide of potassium and syrup of iodide of iron. All these processes work slowly in recession, as in advance, and there is susceptibility of recurrence on exposure. Nevertheless, rhinitis is as amenable to treatment as analogous affections of the other parts of the body.

Pulmonary Hemorrhage.

Prof. ALONZO CLARK (*Med. Gazette*). There are two or three things employed for this purpose that are mainly relied on just now for the suppression of

the bleeding. First, the fluid extract of ergot; and I believe it is as efficacious as any medicine we can give internally. But there is something still more efficacious. By temporarily stopping somewhere in the system, a certain quantity of blood, and holding it there for a few minutes, the effect of which is to relieve the lungs. When the hemorrhage is moderate, dry cups serve this purpose; a dozen of them may be applied, they hold the blood in the capillaries and keep it out of the general circulation so long as they are applied. I was attending a case of effusion at one of the hotels here, and a case of as obstinate a hemorrhage as I have ever seen. It was in a young man, a merchant's clerk and he was running down very rapidly. The flesh was melting away from him, he would have hemorrhages every day, perhaps two, sometimes three. Though each one could be stopped, the occurrence was so frequent, that he was losing life. Dr. Detmold was called in consultation and seeing the danger of the case said, "why not resort to the same plan that is used in the army, for stopping hemorrhages in persons who have been shot through the lungs?" I said "yes, certainly." Well said he, "let us tie up one of his arms as if for bleeding." A bandage was put about one of the arms and the blood accordingly accumulated in the veins so that the hands and arms were swollen, when the arm filled with blood the hemorrhage stopped. We held the blood there in the veins for perhaps four or five minutes and then tied the other arm and allowed the blood from this to flow out into the general circulation, and in perhaps ten minutes, we left him to himself and the bleeding did not occur that day again.

The next day there was but little hemorrhage. Whenever the hemorrhage was

dangerous, he was instructed to have the arm tied up in that way and he got well enough to go back to his work. While he made but slow progress, he was able to work two or three years after that, then he went to Europe and I don't know but that he died there. I have resorted to that expedient in a great many cases since and had never found it fail as a temporary relief. Do not allow the blood in the vessels long enough to coagulate there. Not knowing exactly in what time it would coagulate, I prefer to liberate the blood in one arm after the ligature has been applied for five minutes, and if necessary tie up the other arm or tie a leg; confine a portion of blood out of the circulation for a little while and the hemorrhage will almost invariably stop.

Ergotine in Pharyngitis.

The *Revue Mensuelle de Laryngologie*, indicates a therapeutic method which may give good results in cases of chronic pharyngitis, complicated by exaggerated enlargement of the pharyngeal veins, and muco-purulent secretions. It advises the use of—*R.* Ergotine, gr. xv; tincture of iodine, 3 j; glycerine, f 3 viiss. *M.* To be liberally applied, twice a day, on the pharynx, by means of a brush.—*Med. and Surg. Reporter.*

Chromic Acid and Tonsillitis.

Dr. D. A. HOGUE, Houtzdale, Pa., (*Med. Brief*), claims that he has successfully treated chronic tonsillitis by the use of the following mixture, applied to the tonsils with a camel's hair pencil. *R.* Acid Chromic 3 i Aquae 3 i M. The prescription was a favorite one with Dr. J. A. Meigs, who had very good results from its use.—*Chic. Med. Review.*

Treatment of Ozæna.

Dr. COZZOLINO, of Naples, has recently written a monograph on this subject. He recommends a pomade as follows:—*R.* Hydrarg. chlor. mit., gr. xxx.; sodii benzoat., 3 i iiss.; sodii salicylat., gr. xv.; thymoli, gr. j.; iodoformi, 3 j.; ung. petrolei, 3 ss.; acidi tannici, gr. j.; rosar. essentiae, 3 j. *M.*

This is to be applied locally, after detersive injections, by Weber's nasal douche.

He recommends prudence in the application of mercurials, and attaches particular importance to a general antiscrofulous treatment.

For ozæna from atrophic rhinitis he recommends benzoic acid, certain mineral waters in douches or in powder, such as the water of St. Christiau, justly extolled before him by Dr. Tilot, and that of Casamicciola, etc.

He is no partisan of the tampons of cotton wool of Gottstein, and prefers to them medicated bougies of gelatine of a form invented by himself—a conical form and 3, 4, or 5 centimeters in length, adapted to the calibre of the nasal fossæ. The object of these gelatinous bougies is that they may remain upon the diseased surface in order to obtain their full action. They are made up with the following ingredients.

1. *Astringent or Anti-catarrhal Gelatinous Bougies.*—Subnitrate, tannate, and salicylate of bismuth, pure tannic acid, sulphate of zinc, and sulpho-carbolate of zinc.

2. *Emollient or solvent Gelatines.* Chloride of sodium, chlorate of potash, chloride of ammonium, neutral alkaline carbonates, employed to dissolve the inspissated secretions in some cases of dry rhinitis.

3. *Modifying or resolving and Specific Gelatines.*—Preparations of iodine and

of mercury, as, for example, iodoform, calomel, or red precipitate for specific cases. The iodide of sulphur in herpetic lesions, and corrosive sublimate in syphilitic affections.

4. *Anti-fetid or Disinfecting Gelatines.* Vegetable charcoal, thymol, salicylic acid, and phenol.

The washing ought always to precede the application of the gelatines and the insufflation of medicated powders. The gelatines are applied alternately in each nasal fossa, especially in the evening. In the morning we ought to introduce the bulb of the nasal douche in the opposite nostril to that in which the gelatine had been applied the previous evening.—*Med. and Surg. Reporter.*

DISEASES OF THE CIRCULATORY ORGANS.

Epistaxis.

Dr. GEO. M. LEFFERTS (*Med. News*), affirms that frequently recurring attacks of epistaxis, especially in children, are in the vast majority of cases due to a small erosion of the mucous membrane of the cartilaginous septum, just above the point of the former's junction with the skin. This is due to the violent removal of a little inspissated mucus which has lodged at that point, and is kept up by frequent repetition of the process. To effect a cure the habit of picking must be avoided and the erosion kept constantly covered by a layer of vaseline or otherwise treated according to special indications on general principles.—*Can. Jour. Med. Sciences.*

Treatment of Obstinate Epistaxis.

A combination of subacetate of lead (twelve parts) and opium (one part), of which two grains (thirteen centi-

grammes) may be given in a pill every two hours, has been successfully used by Dr. Roth.—*Memorabilien, Heft 5.—Med. Times.*

Idiopathic Pericarditis.

Dr. W. G. SMITH (*British Med. Journal*), has recently reported three cases of what he calls idiopathic pericarditis, that is, inflammation of the pericardium occurring independently of injury or other local cause, or of extension from the neighboring parts, and exhibiting no demonstrable relation to rheumatic fever, chorea, the exanthemata, renal disease, pyæmia, tuberculosis, or the puerperal state. He is of the opinion that the rarity of this affection has been overestimated. This fact should especially be borne in mind, as it will tend to keep observers on the alert to detect a formidable disease which often begins in an exceedingly insidious manner.—*Chic. Med. Review.*

Styptic Colloid.

The *Chemist and Druggist* (London), says that the following will instantly coagulate blood, forming a consistent clot, under which wounds will readily heal:—Collodion, 100 parts; carbolic acid, 10 parts; tannic acid, 5 parts; benzoic acid, 5 parts. Mix the ingredients in the above order.

Pulsations of the Liver.

Dr. DRUMMOND (*Dublin Journal of Med. Science*), claims that pulsations of the liver are of much diagnostic importance in tricuspid regurgitation or heart murmurs. He claims that this phenomenon is due to the regurgitation of blood through the vena cava inferior into the hepatic venous branches. The cardiac impulse against the liver is not without influence in producing pulsation.—*Chic Med. Review.*

Glonoine in Cardiac Disease.

Dr. W. E. GREEN (*Practitioner*), claims that glonoine ranks second only to digitalis in the treatment of cardiac disease. He generally gives it in minim doses of a one per cent. alcoholic solution. It is especially indicated in angina pectoris and weak dilated and fatty heart. In the latter it gives relief by reducing arterial tension and thus lessening the amount of work the heart has to do. The drug may at times be advantageously combined with digitalis. It produces a sense of fullness in the head and a general feeling of warmth.—*Ibid.*

Oozing from Leech-Bites.

The application of a small piece of blotting-paper to leech-bites is, in Bellevue hospital, a method used for stopping the bleeding, and one which often gives surprisingly satisfactory results.—*Med. Record.*

Aneurism of Aorta.

Dr. JANEWAY reports (*Med. Record*), three cases of aneurism of the arch of the aorta, in which the first symptoms attracting attention was cervico-brachial neuralgia.

DIGESTIVE TRACT.**Obscure Epigastric Pain.**

In the *Lancet* Dr. EDWARD B. GRAY reports a curious case of obscure chronic epigastric pain, in a man otherwise apparently healthy, which teaches how difficult it is to diagnose duodenal ulcer. The patient, aged fifty-eight, had complained of pain "across the pit of the stomach and through the loins" for two years. He was well nourished, appetite good, epigastrium only slightly tender to pressure. He was regarded by his

friends as a hypochondriac. Suddenly he vomited over twenty ounces of bright-red blood. He was ordered twenty minims of the tincture of the perchloride of iron every three hours, to keep to ice and iced water, and to remain absolutely at rest on his back. About midnight of the same day he passed between a pint and a half and two pints of clotted blood from the bowel. He passed no more blood, but two days subsequently he was suddenly seized with severe epigastric pain, fainted, and died in a few minutes. At the post-mortem, the stomach and intestines were found full of blood. The sole lesion discovered was a small, deep, ulcer, of the diameter of a split pea, clean punched out of the otherwise healthy mucous membrane of the duodenum. At the bottom of the ulcer was a small perforation in the pancreatico-duodenal artery. The other abdominal organs were healthy.—*Ibid.*

Aloetic Pills.

M. AUDHOUI, in *Le Médecin Praticien*, considering that the preparations containing aloes in general use are of too irritating a nature, recommends the following pill mass, which he constantly uses :

R. Aloes pulv., 3 ss ; potass. bitart. pulv., 3 ss.; sapo. amygdal., 3 j.; acacie gum pulv., 3 ss.; syr. simplic., q. s.

Mix carefully the powders and soap, add the sugar and divide into 100 pills.

M. Audhoui prescribes one, two or more of these pills, according to the condition of the digestive organs, after meals.—*Ibid.*

Aconite in Acute Dysentery.

Dr. W. OWEN, Port Blair, India (*Indian Medical Gazette*), reports having treated one hundred and fifty-seven typical cases of acute dysentery with

aconite. He was induced to give aconite by the following considerations: First, Its influence in other acute inflammations. Second, From its relieving internal congestion. Third, It has a marked antipyretic action in febrile cases. Fourth, It has a sedative action on the gastro-intestinal mucous membrane. He gives one minim of the tincture of aconite (British Pharmacopœia) every quarter of an hour for the first two hours, and a minim an hour subsequently, making half a drachm in twenty-four hours. This method has been found by him to be followed by the very best results in the great majority of his cases.—*Chic. Med. Review.*

Oxyuris Vermicularis.

Dr. JAMES P. KINGSLEY writes about these worms in the *St. Louis Medical and Surgical Journal*. They may exist in considerable numbers, and for a long time, in a child without attracting notice by any symptoms of importance. The most frequent symptom is scratching of the anus, especially at night after the child has become warm in bed, an increased amount of mucus at that time favoring the movements of the worms. There are frequent attempts to evacuate the bowel, which in many cases results in the discharge of a small quantity of mucus. Often there is such violent straining at stool that the bowel becomes prolapsed. Sometimes the worms migrate into the vagina, and there excite great irritation, inflammation of the vulva and leucorrhœa. In the male they may cause erection and sometimes balanitis, also pain upon micturition and defecation. Since these parasites inhabit the large bowel only, and usually the lower portion of it, they can readily be removed by the use of proper enemas. The best treatment is the daily

injection of two or three ounces of lime water into the rectum, together with the occasional administration of a mild purgative, either a teaspoonful of castor oil, or one grain of calomel rubbed up with five grains of sugar, at bedtime. A solution of common table salt injected daily answers an admirable purpose. When there is a relaxed condition of the bowel, evidenced by its protrusion when straining at stool, an astringent injection should be used. In such cases he uses the following: *R. Ferri sulphatis, 3 j; infus. quassia; Oj. M. Sig. Inject four ounces every morning.*

The mother or nurse must be careful to wash away all the parasites she can find in the folds about the anus. The great itching that comes on after the patient has gone to bed may be effectually relieved by an application, to and within the anus, of the following ointment: *R. Iodoform, 3 ss; ung. zinci. oxid., 3 ss. M.*

In addition to local treatment, tonics are usually required, more especially in strumous children. The preparations of iron are decidedly beneficial.—*Med. and Surg. Reporter.*

Chloroform in Cholera.

M. DESPREZ gives, in the *Bulletin de Thérapeutique*, a treatment recommended by him in 1857, and which was found very useful in the terrible epidemic at Damas, in 1875, and in India, in 1876 and 1877, the following potion constituting the basis of the treatment:—*R. Chloroform, ʒ xv.; alcohol, f 3 ij.; ammoniæ acetat., 3 iiss.; syr. morphia chlorhydrat., f 3 j—3 ij.; aquæ, f 3 iiiss. M. Sig.—Teaspoonful every half hour.*

Chloroform thus administered seems to act on the spasms and contractions of the stomach.

Liquids introduced in very small quantities are no longer vomited, the

medicament favors absorption, and as it is very rapidly eliminated, accumulation of action need not be feared.

Without insisting on the theoretic part of the treatment recommended in M. Despres' memoir, it must be said that M. Follet, who followed out the treatment at Pondicherry, had a mortality of but 29 per cent., while under other methods of treatment the mortality reached as high as 80 per cent.

This method of treatment is applicable only during the first period of cholera; as soon as the period of reaction sets in the employment of stimulants and narcotics is of more doubtful benefit, and treatment should be modified according to the symptoms and indications.

Gastric Ulcer.

R.—Bismuth sub. nit.; magnesiae carb., ʒā gr. xv.; liq. morph. hydrochlo., ʒ xv.; aqua ad. ʒ i. M.—*Dr. Andrew Clark.*

Influence of Alcohol upon Digestion.

BUCHNER (*Deutsches Archiv für Klin. Med.*), as the result of a series of elaborate researches upon this subject, concludes as follows:

1. Alcohol as such, up to the strength of ten per cent., has no influence upon artificial digestion.
2. Added to the amount of twenty per cent., it retards the process of artificial digestion.
3. In a higher percentage it puts an end to the digestive process.
4. Beer, when undiluted, stops the process of artificial digestion entirely; diluted with water it simply hinders it. Red and sweet wine have the same effect, while undiluted white wine simply retards without suspending the digestive process.
5. In the natural process of digestion

beer appears to act unfavorably even when taken in small quantities; wine acts in the same way.

6. In disturbed conditions of absorption and secretion of the gastric mucous membrane this effect of alcoholic fluids proceeds even to complete interference with the digestive process.—*Med. Times.*

Treatment of Indigestion and Heartburn.

For the purpose of whetting the appetite, and thus acting reflexly upon the gastric secretions, we employ the class of agents known as bitters. To these we add hydrochloric acid. Ringer has pointed out how an alkali taken into the stomach before a meal, when the stomach is alkaline, produces a freer flow of acid afterwards. Consequently we comprehend the value of the well-known preparation indifferently termed, "Haust. Stomach," or "Mist. Mirabilis," or "Mist. Rhei et Gentian," in the various hospitals; a combination of world-wide fame. One drawback to this combination of rhubarb, gentian and soda is, that the student becomes familiar with it and its virtues, but remains ignorant of its exact composition, and so loses sight of it when he enters upon practice for himself. Such a mixture before meals, followed by ten drops of hydrochloric acid after the meal, will often make the difference betwixt imperfect digestion, producing discomfort, and digestion so perfect that it does not provoke consciousness. Or where there is much irritability in the stomach, *i.e.*, when a bare, red tongue imperfectly covered with epithelium suggests a like condition of the internal coat of the stomach, then bismuth is most soothing. The mixture of soda, bismuth and calumba is in use for such indigestion with good results. The dietary in such a case should consist of the blandest food,

milk, with or without baked flour in it, beef tea with baked flour; nothing more till an improved condition of the tongue tells of a more normal condition of the stomach. In such case a plain opium pill at bedtime often soothes the stomach very nicely. Then there are cases where imperfect digestion is accompanied by the production of fatty acids, butyric and others, which add the phenomenon of "heartburn" to the symptoms; or there may be later products formed, which cause the bitter hot taste in the mouth on awakening in the morning or after a post-prandial nap. It is usual to treat "heartburn" by the exhibition of an alkali; but this is not good practice. In union with an alkali the offending matter is nearly as objectionable as in the form of free acid. It is much better to give a mineral acid, as the hydrochloric or phosphoric, which breaks up the feebler organic acid. By such means we can aid the digestive act. Then at other times the indigestion is due to lithiasis, where the presence of uric acid impairs the efficiency of the gastric juice. In these cases all measures which do not entertain the casual relations of the dyspepsia are of little use. By the administration of potash in bitter infusion, well diluted, taken half an hour before a meal, this element of trouble is removed. In all cases of gouty persons suffering from dyspepsia, do not forget this cause of impairment of the gastric juice.—Dr. J. MILNER FOTHERGILL, in *Practitioner*.—*Can. Med. Record*.

Laxatives.

Morning Laxatives should always be taken warm. By so doing their action is more rapid, and the bowels are less apt to tease the patient during the course of the day, which is often very inconvenient.—*St. Louis Cour. Medicine*.

DISEASES OF THE URINARY ORGANS.

Cardiac and Renal Disease.

Dr. SAUNDLY (*Lancet*) is inclined to believe that cardiac lesions may exist for years giving no other than a murmur evidence of their existence, but in these cases the supervention of nephritis is the point of departure for the most marked cardiac symptoms. He is, therefore, of the opinion that there is much error in the commonly accepted view that cardiac affections occurring in nephritic persons necessarily bear a direct casual relation to the renal disease.—*Chic. Med. Review*.

Endocarditis Complicating Diabetes.

In a note presented to the Paris Academie des Sciences, at its session of March 6, 1882, Dr. Lecorché called attention to the comparatively frequent occurrence of endocarditis as a complication of diabetes mellitus. He believes it to be occasioned by the irritation exerted upon the endocardium by blood charged with sugar. Endocarditis appears late in diabetes, usually two or three years after the initial symptoms.—*Med. Record*.

The Treatment of the Vertigo of Bright's Disease.

Dr. ROBERT SAUNDBY says that even while we cannot hope to effect a cure of the disease itself, it is often of the greatest moment to be able to relieve a symptom which is rendering life worthless. Vertigo is not a very common symptom in chronic Bright's disease: but though it does not receive much attention from text-book writers, when present it is a very serious matter to the sufferer, and often takes a pre-eminent place in his own account of himself. After trying various remedies, Dr. Saundby has found the greatest benefit from caffeine or their

doses of one, two, or three grains in pill, three times a day.—*Brit. Med. Journal.*

The Early Diagnosis of Chronic Bright's Disease.

In a discussion on a paper on the above subject, Dr. W. H. DRAPER first alluded to the fact that Bright recognized all the forms of kidney disease which since his time have been more fully described, although he offered no explanation of the morbid conditions. While no fixed characteristic clinical picture of the different forms of the disease had been established, there had been recognized two varieties of chronic nephritis: 1, the large white kidney; 2, the atrophied kidney; and it was to the latter affection that special reference was made in Dr. McBride's paper and the discussion which followed. It was that insidious form of the malady which never began with any symptoms that called attention to the kidney prominently; in which albuminuria might never be a prominent symptom, might never be detected, and in which dropsy was never an initial symptom, &c.

With reference to this affection—the cirrhotic kidney—Dr. Draper directed attention to certain points in etiology.

First—and one of the most important factors—*heredity*, admitted by most authorities on renal pathology. In this connection reference was made to its occasional coexistence with glycosuria, vascular diseases, as cerebral apoplexy, and with ancestral cardiac disease.

Second.—The existence of the gouty habit, whether inherited or acquired. There was a pretty general unanimity of opinion among clinical observers upon that point. Todd, in 1846, first described the shrivelled gouty kidney.

Although a frequent complication, it was regarded by some as merely a coin-

cident associate with gout. Bartels and Dickinson were very positive in their statements that the two diseases had an etiological relation. Granger Stewart was less positive in his statements. Garrod distinctly recognized the frequency of the association of granular kidney with gout. In considering gout in all its relations Dr. Draper regarded it as essential to observe it as a general disease, of which lithæmia and trophic changes were important factors.

Third.—*Senility*.—The cirrhotic kidney was a disease of declining years. It was extremely rare under twenty years of age; the largest proportion of cases occurring between the ages of thirty and sixty years, a period in which the general failure of the processes of nutrition occurred. This fact pointed toward the conclusion that the granular kidney was a part of the general trophic processes induced either by the limits of heredity or the wear and tear of life.

All these factors should enter into the study of the etiology of the disease, and when closely analyzed point strongly toward the conclusion that the affection was a general rather than local one; and that renal and vascular disease have a common origin in blood dyscrasia.

The theory that there was a functional stage was one which the observations of many clinical observers tended to confirm. For example, persistent high specific gravity of the urine had been regarded as an important symptom of this stage, high arterial tension, &c. Dr. Draper believed that the proper appreciation of the functional stage of the granular kidney was to be found only in the proper appreciation of the etiological factors considered: 1, heredity; 2, gouty habit; and 3, senility; and probably, then only a conjectural diagnosis of the formative stage would be reached.—*Med. Record.*

M E D I C I N E .

CONSTITUTIONAL DISEASES.

On the Diagnosis of Trichinosis in Man.

Probably a majority of isolated cases of trichinosis are never diagnosed, and even epidemics have passed unnoted, through ignorance of the symptoms caused by the parasite. In a recent lecture delivered at the Hotel Dieu, Paris, by Prof. GERMAIN SÉE, reported in the *Med. Press and Circular*, we find an able presentation of the symptoms of the malady, under the following heads :

1. *Gastro-intestinal Form*.—Trichinous individuals are taken, without apparent cause, with serious digestive derangements; epigastric *malaise*, with a sense of fullness; nausea, vomiting. The time of vomiting is variable; sometimes it takes place on the same day that food was taken, or the day after, or three or four days. These gastric troubles are often attended by diarrhœa of a choleraic type. The physician may treat the case as one of simple indigestion, or may believe it choleraic. The microscope will remove all doubt. The parasite will be found in the dejections. There are two points worth noting in this form—there is excessive perspiration and extreme muscular prostration.

2. *Rheumatoid Form*.—In this type muscular pains predominate. Patients experience great fatigue, accompanied by violent pains, which prevent movement. There is a sort of weakness, painful paresis. About the eighth day the muscles became swollen and hard as a plank, very sensitive to pressure. If the trichinæ have invaded arms and legs, test the muscles, the flexors are

always more seriously affected than the others. Palpation gives a feeling of hardness, but the muscles of the limbs are not the only ones attacked. The trichinæ may fix themselves in the muscles of the jaw, pharynx, larynx and eye. The muscles of respiration, especially the diaphragm, are always attacked. Dyspnea may be observed, but this will vary according to the number of parasites fixed in the muscles of respiration. Pain is a leading symptom, and this pain may be put down to rheumatism, syphilis, neuralgia, etc. The physician will, however, be on his guard if gastro-intestinal trouble has been previously noted. The muscles may be pierced by the trocar of Duchenne or the harpoon of Modells, and the trichinæ sought for in the fragments removed. This is not a certain test, for you may take away a fragment of muscle perfectly healthy which may be alongside a completely trichinized fasciculus. It is better to make a retrospective inquiry as to what the patient has eaten.

3. *Edematous Form*.—This is the most characteristic type. Patients come to you with their faces swollen, especially their eyelids, complaining of extreme prostration. This edema may be unilateral when it is, so to say, pathognomonic, or it is dual. Not finding anything the matter with the heart or the kidneys, cachexia is expected. When joined to these symptoms we have muscular weakness and gastro-intestinal disturbance, the diagnosis is simplified. This edema may become general or give place to edema of the extremities. This is explained by disturbance of the cir-

culatation by obliteration of the small vessels by the trichinæ.

4. *Typhoid Form*.—This form of trichinosis presents more than one analogy with typhoid fever. The temperature is raised and the fever continued. The aspect, prostration, respiratory trouble recall the onset of typhoid. The acute pain may be put down to spinal derangement. These phenomena will assist you: (a) The profuse perspiration which does not exist in typhoid fever, where the skin is excessively dry; (b) the edema of the face, observed in nine cases out of ten in trichinosis; (c) the rapid subsidence of the fever. I might make a fifth class under the name *nervous*. M. Le Roy De Mericourt believes that there is a certain analogy between these symptoms and those of *acrodynia*, which prevailed in Paris in 1829, and which may be attributed to poisoning by trichinæ. I might speak of the various furuncular, miliary, pustulous eruptions which have been noticed in a certain number of cases.

Résumé.—The four forms of the malady which I have just described may combine, though intestinal disturbance may be absent; yet the muscular pain, the intestinal disturbance, and the swelling of the face will almost constantly be found. The typhoid form is usually seen in those cases which terminate fatally, death taking place from the twelfth to the thirteenth week, with stupor, delirium, and all the phenomena of adynamia. This short sketch will put practitioners on their guard against error and facilitate the diagnosis of trichinosis.—*Louisville Med. Times*.

Jaborandi in Typhoid Fever.

In the course of an article on this subject in the *Medical Press and Circular*, Dr. RICHARD RYDER says that,

having had his attention called to the value of sudorific treatment in the early stages of typhoid fever, he has used jaborandi extensively, and believes it to be the most valuable we possess, in the early stages, not only of febrile, but in acute and inflammatory affections, whether arising from cold, blood poisoning or other causes. He believes jaborandi to possess the power of eliminating from the human system, through the skin, almost any specific poison, if resorted to at once and before the poison has had time to set up its specific action. He says:

"My attention was first called to this plan of treatment many years ago by hearing of a gentleman who held the position of resident physician to a large fever hospital. His belief was that he had frequently contracted both typhus and typhoid fever in the discharge of his duties, and his novel mode of arresting it was to mount his horse and ride for ten or fifteen miles, regailing himself on the road with sundry glasses of whisky punch. He would then return in a bath of perspiration, and feel no more of his dreaded enemy.

"A short time after hearing this account I saw a lady who had been suddenly taken ill with all the premonitory symptoms of typhoid, and as she had suffered but a short time before from that disease, she was convinced in her own mind of the nature of the attack, and, on being questioned, said: 'I feel exactly as I did when I was sickening for typhoid fever.'

"I immediately resorted to active sudorific treatment, assisted by numerous blankets, covering all with a mackintosh sheet, to prevent the least evaporation. I then kept up the action of the skin till all the abnormal symptoms had subsided. In less than ten hours from the time of commencing the treatment

the patient was convalescent, only complaining of weakness. That is more than twelve years ago, and since then I believe I have been the means of arresting a very large number of similar cases.

"The great difficulty I found in most cases was to produce a free action of the skin; if I could only produce that I had little fear for the result. The introduction, therefore, of jaborandi as a therapeutic agent, was hailed by me as one of the most valuable additions to our materia medica. I look on it, in the early stages of fever, in the same light as salicylate of soda in acute rheumatism. I have found it reduce the temperature to its normal standard within a few hours, removing at the same time all abnormal symptoms.

"The preparation of jaborandi which I find the most convenient and reliable is the fluid extract. The dose being small, it is not likely to produce nausea or sickness. Some patients are more impervious to its effects than others. So I begin with the minim dose, gradually increasing it every hour till the full action is obtained. The effects are more readily induced by putting the patient into bed between the blankets.

"The sweating usually commences in from three to five minutes, if the dose is sufficiently large and the preparation a reliable one. If there is no action of the skin from the first dose, within the hour I repeat it, giving double the quantity for the next. In conclusion, I must say that I have the most implicit confidence in this plan of treatment, and believe that jaborandi will effectually stop an attack of fever if taken in its first stage. But it frequently occurs that the medical man does not see the case till it is too far advanced to derive any benefit from it."—*Med. and Surg. Reporter.*

Antipyretics, Etc., in Typhoid Fever.

The fever in typhoid is naturally a very exhausting one. The patient emaciates rapidly, because of the active combustion of the tissues, due to the high temperature. When the fever is at its height, the patient usually assumes the dorsal decubitus, and shows all the signs of supreme exhaustion. There is no muscular movement, no expression in the features, but a vacant and dull look. Sordes collect on the lips, teeth, and nostrils.

The fever is simply the using up of the patient, consuming the energy that is set free. Hence, for each degree of reduction the danger is correspondingly lessened. To reduce the temperature is, therefore, the most essential feature.

Proper adjustment of the clothing, proper attention to food and drink should always receive careful attention. Besides their cooling effects, drinks also facilitate peristalsis, and assist in removing matters produced in the retrograde movement. It may even be necessary to act on the bowels to depurate the system of these effete materials.

Rest.—Rest is absolutely essential. The patient should be protected from any source of irritation, and there should be no muscular movements whatever. This should be insisted upon, as patients often exhaust themselves greatly during the early stages of the disease, and thus lessen materially their chances of recovery.

Diet.—A milk diet is the best in the great majority of cases. Some patients cannot take a purely milk diet for a long period. In such instances animal broths may be given. But these must be fluid, concentrated, and rich in all the elements of animal fibre, and not merely a solution of a few salts with extractive matters.

Quinine.—Extraordinarily large amounts of this drug are needed. The

striking effect of quinia shown in this patient cannot be looked for in small doses. In other fevers, *e. g.*, malarial, surgical, etc., quinine thus administered exerts its specific power, but moderate doses in typhoid fever produce no such effect.

Alcohol.—In regard to alcohol as an antipyretic in typhoid fever, and in fact all high grades of temperature from any cause, there can be no question of its ability. Alcohol is an antipyretic in that it does reduce the temperature. At the same time its action in fevers is explained not only by its antipyretic effect, but also by its stimulating and supporting the heart, and by supplying something, a "food," out of which force is eliminated for the vital functions. Hence its utility in fevers. It is a very unstable hydrocarbon, and is, therefore, very combustible. In the body it has the same combustibility, and thus eliminates energy and obviates the loss and exhaustion resulting from the combustion of the patient's tissues. The same would obtain of any food, the latent force becoming the active energy of the body.

One of the most striking effects of alcohol is the almost utter impossibility to intoxicate in high fever. When alcohol circulates in the blood, when it produces its specific effect, it intoxicates. But when consumed like any other food, this specific action is not shown.

The power to digest alcohol varies in different persons. In some a teaspoonful may cause intoxication. Others take large quantities in health and experience no effect whatever. This is principally due to a greater power of digestion for alcohol. The same is found even for ordinary foods. In febrile conditions, however, the ability to consume is uniform. In typhoid and similar fevers a patient will take large quantities of alcohol (even a quart of brandy in twenty-

four hours) without any of the usual symptoms of alcoholism, any of the cerebro-spinal effects, or even any odor upon the breath. Also, the patient is not only not rendered delirious but the delirium is quieted by alcohol; he thus obtains possession of his senses by those means which under other circumstances would deprive him of them. This action of alcohol is of specific value, not only in typhoid but in all fevers, and at all ages. Even infants are able to tolerate doses in fever that would otherwise set them wild.

There is only one explanation of this. Alcohol being very combustible is oxidized and split up by the fever into its elements, H_2O and CO_2 , water and carbon dioxide, thus by its decomposition liberating its potential force and saving combustion of the patient's tissues.

The feeding of fever, therefore, constitutes one of the most important elements in its treatment. For this purpose alcohol as a food is most easily disintegrated and yields most readily its power. Hence it is indicated in all continued fevers when the patient is suffering from the effects of combustion.

Alcohol also stimulates the nervous centres. The heart becomes more steady and firm, and the first sound, which may have been feeble or absent, becomes distinct. By its stimulating effect it will also quell the delirium and control the locomotor disturbances. In the use of alcohol in fever, it is important to bear in mind the indications for its administration.

Alcohol is required when the patient exhibits symptoms of great nervous prostration, with subsultus, delirium at night, jactitation, with a position in bed indicating great physical debility, and a very dry tongue; all coming on with the increase of temperature.

If alcohol be administered it will

quiet the delirium and the locomotor derangements; the patient will sleep quietly, the tongue will become moist, and the whole aspect of the case will be changed for the better. If, however, it increases the frequency of the pulse, if the delirium becomes more active, the tongue more dry, the skin hot and parched; if the motor spasms, tremulousness, subsultus, and restlessness are aggravated by alcohol, it is doing harm.

In all cases it is important that the temperature fall and the pulse become less frequent until regulated from one twelve hours to another. In regard to the administration, the potent property lies in the amount of alcohol. Brandy or whiskey is preferable to fermented preparations. It is exceedingly desirous to prevent anything like fermentative dyspepsia, hence wines and especially beer should be avoided. Old wines were thought to be excellent. Alcohol does the good, however, and the simplest way is the best. It is best taken with the food; given with milk it is thus diluted and rendered bland.

The amount of alcohol to be administered varies with the patient. This consideration needs careful and intelligent observation of the symptoms. There is no strict law. It should be given until the desired effect is obtained. The amount usually ranges from $\frac{3}{4}$ iv. to $\frac{3}{4}$ xxiv. But in the majority of cases it will be necessary to give the largest quantity in the twelve hours from 6 P.M. to 6 A.M. During this period all the vital powers, the respiration, pulse, and temperature reach their lowest. Therefore the greatest failure in these hours need the greatest amount of stimulation.

In typhoid fever many symptoms may arise which require special attention. Insomnia may be exceedingly distressing, and, as a rule, opium may be used

in moderate doses. It not only produces sleep at night, but helps the patient bear the exhaustion.—*Med. Record.*

How to Demonstrate Tubercle Bacilli in the Sputum of Phthisical Patients.

BAUMGARTEN recommends the following method as more convenient than that employed by Koch, and as equally efficacious: A portion of the sputum is dried on a cover-glass and then treated with potash—one or two drops of a thirty-three per cent. solution of caustic potash added to a watch-glass of distilled water. The tubercle bacilli can then be readily seen with a magnifying power of four or five hundred diameters, and a little pressure renders them still more distinct from the enclosing detritus of tissue. In order to preclude the possibility of confounding the bacilli of tubercle with those of other species, the cover-glass may be raised and placed aside until the layer of fluid on its under surface is dry, and then passed two or three times through a gas flame, and then on it may be placed a drop of an ordinary watery solution of aniline violet or any other nucleus-tinting preparation of aniline. All the putrefaction bacilli appear under the microscope as an intense blue or brown (according to the testing agent and its strength), while the tubercle bacilli remain absolutely colorless, and can be seen with the same distinctness as in the ordinary potash preparation. The whole process does not occupy more than ten minutes.

Amyl Nitrite for Ague.

Dr. SAUNDERS, of Indore, India, reports in the *Indian Medical Gazette* a number of cases of ague successfully treated with amyl nitrite. He asserts that in every instance the disease yielded quickly and permanently to the amyl treatment. He mixes the drug with an equal

volume of oil of coriander to make it less volatile and to cover its odor, and administers it as follows: Four drops of the mixture are poured on a small piece of lint, which is given into the hands of the patient for him to inhale freely; he soon becomes flush, and both his pulse and respiration are much accelerated, and when he feels warm all over the inhalation is discontinued, as the symptoms continue to increase for some time afterward; a profuse perspiration now sets in, which speedily ends the attack, though in some cases the cold stage merely passes off without any hot or sweating stage.—*Therapeutic Gazette*.—*Cincinnati Lancet and Clinic*.

Spiders in Intermittent Fever.

The spider as a remedial agent is suggestive of mediæval therapeutics. Two hundred years ago it was held in considerable estimation as a remedy for ague, and appears to have been derived from the Arabs, who employed the web as a local application. These old notions have induced Dr. OLIVA to make a further trial of arachnidine, and from its use in one hundred and nineteen cases he has drawn certain conclusions, which are published in a Spanish journal: 1. Arachnidine is an agent capable of curing invariably malarial fever, whether quotidian or tertian. 2. Doses of two grams in the adult and one gram in children usually cut the case short at the second attack. 3. Its action is, however, less prompt than that of quinine, which should therefore be preferred in pernicious cases. 4. Being tasteless, it is preferable to quinine in the case of children. 4. Relapses occur less readily with arachnidine than with quinine.—*The Lancet*.

Cure for Chills.

R. Sulph. quinine and ferrum redact, aa 3 i-grs. iv.; ext. nucis. vom., grs. viij.;

mucilage, q. s.; ft. pills No. lxiv.—Sig. Two pills three times a day.

Amyl Nitrite in Malaria, Etc.

To be copied into the practitioner's note-book: Inhalation of five to ten drops of amyl nitrite will break up the chill of malarial fever; so will the hypodermic injection of one-sixth of a grain of muriate of pilocarpine. It is said that twenty drops of oil of turpentine will control the diarrhœa of typhoid fever. Two to five drops of wine of ipecacuanha three times a day will, in the majority of cases, check the vomiting of pregnancy.—*Independent Practitioner*.

Some Clinical Features of Malaria.

Dr. STANLEY M. WARD (*Coll. and Clin. Record*): Having consulted much of the literature on malaria, and having conversed considerably on the subject with practitioners, I have been able to find so little that agrees with my own experience in a certain class of cases, that I venture to write this article, hoping that it may be of some service to others as completely befogged as I was when I first encountered such cases as I describe below.

The locality in which I am practicing formerly enjoyed a good reputation as being free from malaria in all its forms; but for the past five or six years there have been very many cases of intermittents and remittents, and also the, to me, ambiguous cases whose histories I give. The cause of the sudden appearance of this class of diseases is not easy to find, and is, indeed, quite foreign to my purpose here; therefore, without attempting to discover it, I shall give briefly a sketch of three cases of malaria which it seems to me differ largely from the forms usually described.

CASE I.—On Friday morning, June 16th, 1882, I was called to attend C. B.,

male, and found the following train of symptoms: Frontal headache, tightness across the sternum and in the throat, slight, dry cough, dull pain in the bones of both extremities and in spinal column, drowsiness all the time, with but little sleep, on account of headache; his tongue was furred, temperature at 4 A. M. 102, pulse 81, bowels regular, and appetite, which had been very poor, now voracious. There had been no chills or chilly sensation, neither had there been any remission in severity since he was attacked, Thursday afternoon, and I detected no râles of any description. He works in a veneering establishment on the banks of a canal. Some of the workmen have had well-marked attacks of intermittent fever. As he had slept but little, I give gr. $\frac{1}{4}$ morphiæ sulph., and at 8 A. M. he took a capsule containing cinchonidiæ sulph., chinoidin. purif., aa gr. iss. acid. salicylic, gr. ss, capsici pulv., gr. $\frac{1}{2}$ and zingiberis pulv., gr. ss, with orders to repeat every four hours and to report Saturday night. At 7 P. M. on that day C. B. reports himself well, and will resume work Monday.

CASE 2.—Saw A. A., female, housewife, for the first time, on Saturday afternoon, June 17th. She has been sick two days, though she thinks that on Friday she did not suffer so much pain in her head. She now complains of excruciating pain in that region, worse over the frontal protuberances, pain in the bones of the extremities and back. Her appetite is poor, bowels constipated; there is some sweating, but there have been neither chills nor chilly sensations. Her tongue is furred, temperature 102 $\frac{1}{4}$ °, pulse 104. She was ordered five grains of calomel and three of rhubarb, to be followed by a capsule containing the same ingredients as in the other case, except the salicylic acid,

which was omitted, and one-sixth of a grain of resin of podophyllin substituted. Saw her the next Wednesday, when she said she was well.

CASE 3.—E. S., female, doing general housework, was taken ill Saturday, June 24, with headache, pain in the back and limbs; there was some fever and gastric irritation, but no chill. On Sunday there was a slight remission, but on Monday she had a slight chill at 9 in the morning, followed by fever. I saw her about 2 P. M.; she then complained solely of the great pain in her head, back and limbs, and also in her eyes, unless the room was darkened. There were thirst and anorexia, a furred tongue and constipated bowels; she also vomited frequently, the vomiting being especially violent if she attempted to take anything but water or lemonade; temperature, 102 $\frac{1}{2}$ °; pulse, 120; I prescribed calomel and rhubarb, and the capsules the same as in Case number two. Saw patient a few days afterwards on the street; reported herself well.

It is not to be supposed that such histories as I have given are more common here than those of intermittents well marked; on the contrary, we have to deal with malaria in all its forms. I have written these notes only with the hope of drawing attention to a class of cases in which errors in diagnosis are apt to be made. It will be noticed that I have used cinchonidia instead of quinia. I find it acts equally well in the same doses, and it offers the advantage of being much cheaper.

Rötheln.

Dr. BLOCK (*Hospitals Tidende*), attaches great diagnostic importance to the swelling and tenderness of the lymphatic glands, especially of the post cervical glands. This may occur during

the padromal stage, and will then, Block is inclined to think, furnish a valuable means of differential diagnosis between rubeola and r  theln.—*Chic. Med. Review*.

The Prophylactic Value of Salicylic Acid in Yellow Fever.

Dr. WALLS WHITE instructed the captain of a Brazilian-bound vessel to give salicylic acid to his men when he reached his destination. On arriving at Rio Janeiro, it was found that the yellow fever was prevailing. Among the one hundred and fifty ships in the harbor, there was not one that had not had from two to four deaths on board. The captain in question gave his men from five to ten grains of salicylic acid daily, for fifteen days, during which time all the crew remained well. The medicine was then stopped for a few days, but as some of the men began to show prodromal symptoms they were put upon it again. The vessel soon after left the port, having had no case of yellow fever.—*El Siglo Med.*

The Treatment of Diphtheria by the Continuous Spray.

Dr. JACUBASCH reports from the Kinder-Klinik der Charit   some interesting results of the use of medicated vapor in the local treatment of diphtheria during a recent epidemic (*Berl. Klin. Woch.*) He does not employ the ordinary atomizers, but a spray-producer with a capacity of about three litres of water, which is heated by a gas-jet. A special room was set apart for the inhalation, and when the apparatus was put in action it filled the room with an impenetrable mist in a very brief time; this atmosphere was breathed on the average for about six days, and apparently with good result. A one-per-cent. solution of alum was generally used in the atom-

izer. Altogether, thirty-one children, three suffering with croup, twelve with idiopathic and sixteen with scarlatinal diphtheritis, were treated in this series of cases, of whom seventeen died; but it is to be observed in explanation of the mortality that it in reality is small, on account of the malignant character of the epidemic and the bad condition of the cases sent to the hospital. Thirty-three other cases, admitted during the same period, were treated in the usual method without the spray; of these all the cases (four) of croup died, of idiopathic diphtheria six, and of scarlatinal diphtheria eleven, or, in all, twenty-one deaths.

In addition to the special treatment, the internal administration of quinia, or decoction of calisaya, is considered essential, with good food and wine. Cold baths are condemned, but lukewarm baths (20   to 25   R.) are often of great service in reducing restlessness and high temperature. Tracheotomy was successfully performed under the spray, and antiseptics are recommended to dress the wound subsequently, the canula being removed on the fourth day, but reinserted at night for a short time longer. The success of the treatment given by the author is illustrated by the notes of several cases in the paper. No bad effects were noticed.—*Med. Times*.

Diphtheritic Conjunctivitis Treated with Quinine.

*In the *Lancet*, Dr. JOHN TWEEDY records four cases of pseudo-membranous (diphtheritic) conjunctivitis, in which he derived most satisfactory results from the local use of a solution of quinine. Three of the four cases occurred in men and one in a woman. Two began as purulent conjunctivitis, of gonorrh  al origin, and two were pseudo-membra-

nous from the first. As soon as the nature of the disease was definitely recognized, all other treatment was stopped, and quinine lotion, containing four grains of sulphate of quinine, with a small quantity of dilute sulphuric acid (to effect a solution), to an ounce of water, was alone used. As far as possible the diseased surfaces were kept constantly bathed with the solution, the conjunctival sac being converted, as it were, into a trough, holding the quinine lotion. A bowl of the solution was put within reach of the patient, who was directed to wash the eye frequently, and in the intervals a well soaked compress was kept constantly applied. The house surgeon visited each case three or four times a day, when he would evert the lids and thoroughly cleanse the conjunctival sac with the quinine lotion.

The superficial, disintegrated portions of the exudation were then gently removed with wet lint, care being taken not to aggravate the inflammation by rough handling, or by rude attempts to tear off the false membrane. Usually the quinine lotion was iced. In two cases the local application of powdered sulphate of quinine was tried at first, or sulphate of quinine rubbed up with an equal part of calomel; but in addition to causing great pain, the powder did not seem to be as beneficial as the quinine in solution, and its use was soon abandoned. The virtues of quinine he believes to be specific in the diphtheritic exudation. Three of the cases recorded were at first treated by frequent ablutions, with a five per cent. solution of carbolic acid, and in every instance the pseudo-membranes rapidly spread under these applications, whereas they were immediately controlled by the quinine lotion.—*Med. and Surg. Reporter.*

Remedy for Diphtheria.

A Russian doctor has discovered that compound decoction of senna in sufficient quantity to produce liquid stools, followed by a cooling draft with some hydrochloric acid in it, and a gargle of hot milk and lime water to be used every two hours, "generally leads to a rapid recovery of diphtheria patients."

Treatment of Diphtheria.

Dr. J. W. HAWKINS (*St. Louis Cour. of Medicine.*) The indications to be met are, first, if there is not already vomiting and purging, to give a teaspoonful of the flowers of sulphur, which should be repeated every three hours until the offensive accumulations are carried off. After this the next and most important indication is, without any regard to the existing fever, to begin with such constitutional remedies as will most effectually obviate the characteristic debility that so constantly attends the disorder.

To do this there are no remedies known to me that are so constantly attended with successful results as the sulphate of quinia and the soluble citrate of iron.

These may be combined or given separately. A convenient way of administering these medicines to children, and at the same time I think the best way is :

R. Sulph. quiniæ, 3 j.; ferri citrat., grs. xx.; aquæ desti., 3 ijss.

M. S.—Teaspoonful every three hours. This for a child three years of age answers the purpose very well, and should be kept up in severe cases day and night until the disease is subdued. After this a dose of the mixture daily for two or three weeks will be necessary to prevent a relapse. The iron alone will often answer this purpose. For adults or children large enough to swallow a pill, the ferri et quiniæ citratis may be made into a two grain pill and alternated with

the foregoing mixture. This preparation of iron I believe to be superior in this disease to any other salt of iron, and should never be exchanged for the tinct. ferri chloridi. In addition to the quinia and iron, small doses of potassa chlorate, two grains every three hours, may be given. This will be useful in supplying the blood with oxygen. Local remedies are useful in cleansing the throat and destroying the fungous formations. For this purpose one or two applications of the solid stick of silver nitrate, followed with a gargle compound of two drachms of potassa chlorate dissolved in a glassful of water, or diluted sulphuric acid. If the parts have a ragged appearance, and are disposed to bleed, Monsel's solution of iron is the best remedy.

Externally the throat should be frequently bathed with salt and water, especially early in the attack. A useful liniment is composed of a drachm of sulphur and four ounces of turpentine, and should be frequently applied, especially during the last stage of the disease.

This course of treatment, with some trifling variations, I have found almost uniformly successful.

Treatment of Facial Erysipelas by Scarification and Opium.

Dr. V. NETZETZKY, of Asiatic Russia, describes a treatment of erysipelas successfully practised by native barbers. It consists in superficial vertical scarifications made by a razor over the whole diseased surface. After the bleeding spontaneously stops the affected parts are moistened with an aqueous solution of opium (gr. ii. ad 3i.), and covered with a layer of cotton wool.—*London Medical Record*.

Erysipelas—Local Treatment.

R. Acid phenic, alcohol, āā 1 part; spts. turpentine, 2 parts; tr. iodine, 1 part; glycerine, 5 parts.

This mixture produces no pain, and can be applied every two hours.

Internally, quinine and digitalis when there is fever, vomiting, etc.—Dr. ROTHE in *Memorabilien*.

Carbolic Acid in the Abortive Treatment of the Eruption in Small-Pox.

New and plausible methods or facts sustaining new methods are always sought for eagerly by the profession, though they usually accept them with a more than usual degree of caution. Now Mr. M. D. Makuna comes forward with a paper which he has read before the Medical and Chirurgical Society of London, in which after enumerating the various ectrotic plans that have been suggested from time to time, he recommends that one first introduced by Dr. Eades, of Norwich, in 1878, and subsequently employed by Sir Joseph Fayrer. It consists in cauterizing the vesicles with carbolic acid. Mr. Makuna finds that eruptions on the face, under the carbolic application, reach the end of the pustular stage in four or five days, while similar eruptions on the body which naturally are far less severe, without the carbolic application, do not mature until many days later.—*Lancet*.

To Prevent Pitting in Small-Pox.

GEO. CARRICK recommends the application of rubber in chloroform, as first suggested by Dr. Smarth, of Edinburgh. A four-ounce vial half full of chloroform is to be filled three-quarters full with small pieces of pure rubber. It should be shaken every hour until the rubber is dissolved, making a thick liquid of about the consistency of mo-

lasses. The face must be painted with solution, beginning as soon as the eruption appears, and repeating it from three to five times a day. In any case where the rubber coating gives way, and pus exudes, the application must be renewed at once. As the chloroform evaporates very speedily, a thin film of pure rubber remains upon the surface, and protects it from the action of the air. The application must be kept up until the crusts begin to loosen on other parts of the body.—*Translated from Vratsh, in Phys. and Surg.*

Calcium Sulphide in Small-Pox.

Dr. R. H. COWAN, of Richmond, Va., writes :

"Since reading in a recent number of the *Record* a report read before the New York County Society on the use of calcium sulphide as an antisympthematic, the administration of this drug in small-pox has strongly suggested itself to my mind. As our means of combating this fearful disease are so limited, and the results of treatment so poor, it seems to me that calcium sulphide would be worthy a trial."—*Med. Record.*

Vaccinal Cicatrices and Prognosis.

Dr. LANDRIEUX (*Gazette Hebdomadaire*), claims that in deciding prognosis in small-pox, not only the number but also the character of the vaccinal scars must be taken into consideration. The scars are divided into genuine and spurious. In seventy-one cases of small-pox having more than three genuine vaccinal scars, three died. Of ninety-eight cases with less than three genuine scars, twelve died. Of one hundred and forty-three cases with more than three superficial scars, twenty-nine cases died. Of one hundred and thirty-three cases with three or less vaccinal scars, thirty-

one died. These figures tend to indicate in a general way that vaccinal cicatrices may be of value in determining the prognosis of variola.—*Chic. Med. Review.*

DISEASES OF THE NERVOUS SYSTEM.

Napelinne as a Hypnotic.

NAPELINNE, according to certain recent researches, seems destined to be a valuable hypnotic. Laborde (*Annales Médico-Psychologiques*, January, 1882,) has found it to produce calm slumber in animals. In man it has been tried in doses of nine-tenths of a grain, in facial and intercostal neuralgia and sciatica with very good results. The alkaloid is amorphous and easily soluble in water, alcohol or ether.—*Chic. Med. Review.*

Hyoscyamia as a Depressor Motor.

The London *Medical Record* says that Dr. Seguin has recently published some valuable observations on this subject. He has used it in paralysis agitans, and choreiform affections with very striking results. In a case of paralysis agitans of four years' duration, where the patient had been under the care of several eminent specialists, and had received, without benefit, a great deal of treatment, including sedatives, counter-irritants to the spine and hypodermic injections of strychnia, he ordered the following formula :—

R. Hyoscyamiæ (Merck's cryst.) gr. j ; glycerina ; aquæ destillatæ, aa ℥c ; acid carbol. pur., gtt. ss.

M. Mix, filter with care, and label "Hyoscyamia solution for hypodermic use, ℥j=1 grain."

The patient was given an injection of four minims ($\frac{1}{50}$), and half an hour later all tremor had ceased, the mouth was parched, and the pupils were dilated. An hour after there was great dimness

of vision, extreme dryness of the mouth, and slight delirium. Four hours after the injection these symptoms had in a great measure passed away; but the hands were still absolutely quiet, and the tremor only very gradually reappeared during the ensuing two hours. On subsequent days, three or four minims were injected, with invariably the same results.

Apomorphia in Epilepsy.

Dr. MARTHE (*Revue Médicale de la Suisse Romande*), reports having secured good results from the hypodermic injection of five milligrammes of apomorphia in the case of noisy and violent epileptics and lunatics. This remedy did not act as a derivative as vomiting did not follow its use. The action was only temporarily sedative and not curative.

The Cure of Epilepsy by Ligature of the Vertebral Arteries.

Dr. WILLIAM ALEXANDER reports, in the *Medical Times and Gazette*, five cases of epilepsy greatly improved by tying one or both vertebral arteries, and states that the three cases previously reported (*ibid.*, November 19, 1881), have remained free from fits from that time. As all of the cases were nearly or quite idiotic, and confirmed epileptics, the results are no less astonishing than gratifying. The operation is performed by making a linear incision outside of the sterno-mastoid muscle, and outside of the veins which converge to the lower third of the outer border of that muscle. The subcutaneous tissues are next cautiously divided, until the finger can be inserted into the loose fatty tissues that lies inside of the scalenus anticus muscle. Upon retracting the sterno-mastoid, with the subcutaneous veins and the internal jugular vein, towards the middle line, the sulcus, towards which the ver-

tebral artery runs, is exposed, when a little scratching with a director will expose the vessel, the ligation of which is then a matter of routine.

A curious physiological fact was noticed. When the vessel is ligatured, the pupil on that side becomes contracted, and in the majority of cases it remains so. Tying the opposite vertebral, the opposite pupil contracts, and the pupils again become equal. The effect upon the mental condition of the patient is good, both directly and indirectly, and the intelligence is decidedly improved. Dr. Alexander has tried this operation in hereditary cases, and in epilepsy following scarlet fever, blows, fright, and in cases where no cause could be ascertained. In all the effect was beneficial and mostly curative, so far as time permits him to judge. Further observation may establish this as the best method of treatment of confirmed and otherwise hopeless epileptics.

Loss of Weight after Epileptic Fits.

Dr. C. E. BEEVOR in the *British Medical Journal* denies the statement as made in Dr. Gowan's work on epilepsy that a loss of weight of from one to twelve pounds is seen after an epileptic seizure. This reminds us of the tale of the French acadamecian. For a long time it was stated that a fish could be immersed in a vessel full of water and no water displaced. The statement passed as "Gospel Truth" until some one a little less foolish than the rest tried it. The water ran over of course. So it is with many of the statements in medicine bordering on the fabulous. Appealing, as they do, to the love of the wonderful, they pass current for truth until some incredulous individual takes courage enough to challenge the statement. Query in the above case? Granted a man of average weight, say one hundred

and fifty pounds, number of fits per week two and the nutrition of the patient below par as it would be, how long would it take before undertaker would be called.—*Chic. Med. Review.*

On the Treatment of the Different Forms of Nervous and Neuralgic Headache.

Dr. WILLIAM HENRY DAY (*Med. Times and Gazette*), London:

It is important to recognize the fact that nervous headache, or migraine, is purely neurosal, and not dyspeptic in its origin. The violent vomiting which often follows prolonged nausea is attended, it is true, with the vomiting of bile, but this is no indication in these nervous headaches that the liver is congested or even disordered. It merely points to the violence of the retching which causes the contents of the duodenum to regurgitate into the stomach, as in violent sea-sickness. There must be other accompaniments of hepatic disorder, as sallowness of skin, foul tongue, or clay-colored stools, with altered bile, to prove that the hepatic functions are primarily disordered. The more the brain is attacked as the source of the evil, and the less the stomach is worried with mercurials and aperients, the better, for by irritating the alimentary canal the general health is lowered, and the patient's increasing debility renders him or her the more liable to frequent recurring attacks. Put aside, then, the liver, and the stomach, and the intestines as the origin of the evil, and seek its explanation in some excitement or other alteration in the cerebral ganglia, for it is essentially cerebral. All successful treatment must be based on this understanding. The intimacy between nervous and neuralgic headache is so close that we have, however, to remember that nervous headache which may be

entirely frontal for years does frequently become, with the lapse of time, trigeminal, or one-sided.

The treatment must be considered from two points of view: 1. That during the paroxysm; 2. That during the interval of freedom from acute suffering.

Treatment during the Paroxysm.—

This will in some measure depend on the severity and situation of the pain. In some cases relief comes from the constant application of cold to the head when the pain is frontal, and the vessels are full and throbbing. The head should be elevated on a hard pillow, and a bottle of water applied to the feet so as to draw the blood toward the lower extremities. A nervous headache may now and then be cut short by a drachm of the syrup of chloral, and this may be safely given if the head be hot and the pulse good—if, in short, there be vascular excitement, and the vessels of the brain are too full of blood. If the pulse be small and contracted and the vessels of the head are full and throbbing—if, in fact, the capillaries are in a state of tension, while the hands and feet are cold, it is a good plan to put the patient into a warm bath at 97° for ten minutes, and then to bed. It is astonishing the relief this simple remedy sometimes brings, the skin becoming moist, the pulse softer and fuller, and the "opening and shutting" feeling in the head is diminished as the force of the circulation is lessened.

I may briefly direct attention to *guarana*. In many cases I have found that it has aggravated the nausea and vomiting, and rather increased than lessened the headache, while in a few cases it has proved serviceable, and cut short the headache when other remedies had failed. A few persons tell me that they are never without the powders, taking some occasionally in a little water or tea

when they are going out, and that it always averts a severe seizure.

If the pain continues in spite of all drugs taken by the mouth, if it defies emetics, stimulants, counter-irritants, absolute rest, cold to the head, and warmth to the extremities, then the patient at any risk and at any cost must have relief from suffering.

Chloroform inhalation will occasionally relieve a severe nervous and neuralgic headache when one drug after another has been tried in vain. It does it by inducing sleep. The patient has perhaps endured the most miserable discomfort in the head for a day or two, and the usual remedies afford no relief. Then toward night the pain is aggravated and the patient cannot obtain rest. A few drops of chloroform should be sprinkled on a piece of spongiopiline, and then cautiously inhaled. It should only be attempted by a medical man, who would be as careful in its administration as if he were sending a person to sleep for a surgical operation. A person may be kept slightly under its influence for an indefinite period, and safely so, if the ordinary precautions are observed.

The utility of hypodermic injection of morphia in the acute forms of nervous and neuralgic headache is, in my opinion, under-estimated by the profession. It deserves to be placed in the first rank of all remedies for the relief of this agonizing affection when it has reached a certain crisis. It is impossible to over-estimate its value when there is nothing in prospect but an increase of pain, and a degree of restlessness and irritability over which the patient can exert no control whatever. Then the wakefulness adds to the exhaustion and increases the pain. If the injection only brings temporary relief it enables the patient to recover strength a little, and

to bear the return of suffering with some degree of fortitude. Experience fully justifies me in saying that the hypodermic injection is most safely employed when the circulation and pulse are good, before the pain has caused much exhaustion. Still there are cases that yield to the subcutaneous action of the drug when there is great sickness and prostration, and the extremities are cold and the pulse is weak. If the patient has reached this terrible stage I believe we ought to use it in very small quantity, watching the patient meanwhile to guard against a comatose condition. One-sixth to one-fourth grain of morphia and one-sixtieth to one-thirtieth grain of sulphate of atropia will often send off a patient speedily into blissful rest. I usually employ double this quantity to a patient who has been a miserable victim to these nervous and neuralgic headaches. The atropia obviates the tendency to sickness, and is a most valuable addition.

2. *Treatment during the Interval of Freedom from Acute Suffering.*—This consists in endeavoring to correct any disorder of the general health, for until this has been attended to no special drug for the relief of the head will be of any service. If there be menorrhagia, or bleeding piles, leucorrhea, uterine or ovarian disease, these conditions must be first attended to, and until they are relieved the headache is certain to continue. The avoidance of fatigue, excitement, and all other common causes of headache, with a rigid dietary, is sometimes efficacious in warding off these attacks. If the brain be overtaxed in any way, and certain articles of diet and fermented liquors are indulged in, they disorder the stomach, and forthwith throw the nervous system off its balance.

Now, change of place and scene has a

most important bearing on the treatment of nervous headache. Some persons suffer mostly at home, where they cannot escape the daily anxieties and duties of life, and others suffer when on a damp soil and during the prevalence of cold winds.

Having made our diagnosis of the particular form of headache and selected our remedy, we ought to give it a fair trial. A remedy should not be lightly abandoned in chronic disease, for over and over again it will be found to cure when persevered with, and the system is slowly brought under its influence. The tendency is to hastily exchange it for some other if it fails to do good at once, but this is an error to be avoided.—*Louisville Med. News.*

DISEASES OF THE RESPIRATORY ORGANS.

A New Remedy for Asthma.

From more than one quarter it is reported that Australia possesses a valuable remedy for asthma, which might with advantage be more generally known. A species of *Euphorbia* indigenous to Queensland, and designated *E. pilulifera*, is used locally with the best results in asthmatic and bronchial affections. An ounce of the leaves of the plant placed in two quarts of water, and allowed to simmer until the quantity is reduced to one-half, affords a medicine which, taken a wineglassful at a time twice or thrice a day, is credited with the power of relieving the most obstinate case of asthma, as well as coughs and ordinary chest affections. The leaves may easily be gathered and dried, and will keep for a considerable length of time. Other species of the *Euphorbia* have already acquired some reputation for their medicinal virtues; thus the leaves of the

E. nereifolia are prescribed as a purgative by the native practitioners in India, while the root of the *E. ipecacuanha* is said to be equal in all respects to the true ipecacuanha.—*Medical Times and Gazette.*

Treatment of Phthisical Cough.

Mr. T. GARRETT HORDER (*British Med. Journal*) strongly advises hydrobromic acid in doses of twenty minims. It may be given with the addition of spirits of chloroform. He has also found the inhalation of the vapor of iodine very useful in chronic cough.

Another correspondent recommends fifteen minims of hydrobromic acid and ten minims of chloric ether in a dessert-spoonful of water four or five times a day, with a pill containing a quarter of a grain of codeia three times a day.

Mr. A. de Wihter Baker (Dawlish) recommends the following formula:

R. Tincturæ pruni Virginianæ, ʒj.; glycerini, ʒss.; nepenthe (Ferris & Co.'s), ʒv.; aquæ, q. s. M.

He generally orders it to be given when the cough is troublesome, and repeated in three or four hours, if required. In troublesome cases he also orders a double dose to be given at bedtime. He has never known it to fail to relieve cough; and it can be taken for a long period of time without disturbing the digestive organs.—*Med. and Surg. Reporter.*

The Bacillus of Tubercle.

Dr. KOCH, certainly a careful and painstaking observer, who pointed out the sources of error in some recent experiments of Grawitz on mould, claims to have discovered the bacillus to which tubercle is due. His results (*Berliner Klinische Wochenschrift*), which have roused the enthusiasm of Tyndall,

amount not only to the description of a new bacillus but to the demonstration of the fact that this bacillus can be cultivated in special culture fluids, and can, if inoculated, produce tuberculosis in animals. The new bacillus somewhat resembles in appearance the bacillus lepræ, is rod shaped and its greatest length is about one-half or one-fourth the diameter of the red globule. Tuberculosis has long been regarded by many authorities as at one time an infectious disease like the "lung plague" of cattle, but which had lost its infectious nature by the race becoming partially inoculated with it through hereditary transmission. If Koch's experiments should be ultimately established on a firm basis, it is not impossible that the ravages of tuberculous phthisis will be in the future at least lessened.—*Chicago Med. Review*.

Borax in Hoarseness.

This salt has been employed with advantage in cases of hoarseness and aphonia occurring suddenly from the action of cold. The remedy is recommended to singers and orators whose voices suddenly become lost, but which by these means can be recovered almost instantly. A little piece of borax, the size of a pea, is to be slowly dissolved in the mouth ten minutes before singing or speaking. The remedy provokes an abundant secretion of saliva, which moistens the mouth and throat. This local action of the borax should be aided by an equal dose of potassium, taken in warm solution before going to bed.—*La France Médicale*.

Iodoform to Mucous Surfaces.

Application of iodoform in diseases of the mucous membrane (B. FRANKEL, *Berl. Klin. Wochenschrift*, p. 252), have

been found very beneficial in the following chronic affections of the cavities of the nose, pharynx, larynx, lungs, uterus, and of the conjunctival sac :

(1) Tubercular ulcerations of the larynx are powdered with iodoform once a day. Ulcers appear cleaner, show granulation growth, whole local morbid process retarded, but not cured; subjective symptoms improved.

(2) Phthisis pulmonalis is treated with vapors of iodoform (bottle half filled with water, iodoform thrown in; heating to 190° F. creates iodoform vapors), or inhalation of etheric solution of iodoform (1:60); subjective symptoms, especially cough, improved; fever reduced.

(3) Atrophic retro-nasal catarrh is treated with iodoform powder blown into nostrils or snuffed up, or the iodoform ointment (1:10 vaseline) applied on swab or brush, with excellent results; new life seems to be imparted to the remaining elements of the mucosa, which become more succulent, its epithelium thicker, formation of crusts subsides. Of course, the same treatment for ozæna, with the same splendid results.

(4) Scrofulous rhinitis. Iodoform (1), tannin (2), vaseline (10), is applied with camel's hair pencil or tampon (the latter on alternate days, into one or the other nostril); the rapidity of the cure is astonishing.

(5) Of course, locally, upon all syphilitic affections of these cavities.

[(6) Applications to endometrium in chronic inflammation of this membrane, in powder or with cocoa-butter.

(7) In follicular conjunctivitis (second stage) in minimum quantities directly applied to follicles].—*Med. & Surg. Reporter*.

MEDICINE.

CONSTITUTIONAL DISEASES.

History of a Personal Attack of Typhoid Fever.

DR. ALEXANDER STEWART (*Glasgow Med. Journal*). Under the above heading, Dr. Stewart concludes a very interesting article, with the following suggestions as to treatment:

I will not enter here at any length upon the treatment, but will confine myself chiefly to such lessons as my personal experience taught me. This experience has impressed upon my mind the necessity of quiet. There should be no tramping of feet nor loud talking—a harsh voice I found particularly unbearable, nor were musical sounds more tolerable. The room should be shaded from the light, for bright light hurts the eyes, and what irritates them stimulates the brain when it needs rest, thus the headache is not aggravated and sleep is not hindered. A more direct means of relieving the headache is the application of cold to the forehead; this gave me temporary relief. Cold water cloths, unless frequently repeated, soon lose their cold, so that if they are used, frequent changes should be attended. The ice-bag soon became useless and irritating. Instead of either I would recommend cold sponges dried so as not to allow the water to trickle down the face. While one sponge is on the forehead, the other can lie in the iced water, and the nurse should attend to their frequent interchange. A current of cold air blown across the face would be grateful, too; this might be managed by an apparatus like the hand or foot spray, the air being made to pass through

a chamber containing ice. Bromide potassium given internally might prove useful in allaying the headache and procuring sleep, but for this latter purpose hydrate of chloral is more effectual, and was given to me on the 15th night with apparently much benefit, both for the sleep and delirium. For pain in the back turpentine stupes are serviceable, but I should not hesitate, if the pain were severe, to use morphia subcutaneously with caution, watching its effect. Iced milk helped to allay my thirst, which was very pressing, and ice to suck was very grateful. During the whole course of illness I took food well and generally as offered—from two to four pints of milk and from two to three pints of beef tea daily. From the beginning of the second week I had two and three wineglassfuls of champagne daily; by the end of the second week and during the third I sometimes had as much as half pint of champagne in twenty-four hours. During the 17th, 18th and 19th days I had altogether about eight ounces of brandy; it was not given till there was evidence of much weakness. I doubt the expediency of giving so much champagne. In ordering stimulants to fever patients, I would be guided by Dr. Gairdner's dictum, that "Alcohol is not food, but medicine." The nurse should be strictly enjoined not to leave the patient for a moment. My own case would have ended fatally had I had strength enough to put my resolve into execution. In purposing to jump out of the window I had no suicidal notion whatever, my sole object being to escape from the disagreeable con-

finement in which I imagined myself detained. I also consider it important to humor the patient; nothing is to be gained by going ostentatiously contrary to his wishes—it will only confirm him in his delusion. I believe it is desirable to have the body-heat lowered if it can be done without interfering with the digestive and assimilative powers, or otherwise with the comfort of patient, but it is doubtful whether a high temperature is more dangerous to life than the unpleasant symptoms which are apt to follow the administration of drugs for lowering it. The “cold bath” seems to me to be too formidable, but a modification of it in the form of cloths, wrung out of iced water, applied to the abdomen, and often repeated till the temperature recedes to 100° , as I have seen done in the wards of Dr. M'Call Anderson, is a much more practicable method, and one I would not hesitate to employ. For correcting torpid bowels, I believe injections of warm water will prove effectual in most cases, and are preferable to aperients given by the mouth. I would be loth to use turpentine in injections on account of its severe effects. During convalescence excesses of all kind—mental, physical and dietetic—should be avoided, and it must be remembered that very little may be “excess” at first. I believe singeing the hair every ten days or so for some months to be the best means for promoting its growth. For disinfecting purposes, Condyl's fluid was used in my case—all the excreta were well mixed with it, emptied immediately, and some of it put into the washed utensils, and the floor well sprinkled every morning. Of ten persons who came into more or less direct contact with me during most of the time I was ill none took the fever.

CONCLUSION.

On March 8, 1880, I weighed 9 st.

4½ lbs.—this was seven weeks after the first definite symptoms. On March 8, 1881, I weighed 10 st. 7½ lbs.—an increase of 17 lbs. in twelve months. Before the fever I never weighed above 10 st., so that, taking the increase in my weight along with the fact that I was never in better health than at the present, I gather that typhoid fever may leave the system, though temporarily debilitated, not permanently so, and with the digestive and assimilative powers more active than before, and mental energy in no way abated.

I shall close this history with the following deductions, viz, in typhoid fever:

1. The disease may begin and advance, at first, very insidiously.
2. The brain may be more affected than the bowels.
3. Patients, while really unconscious, may simulate consciousness so far as to deceive bystanders.
4. Delirious patients, apparently bent on self-destruction, and such as are untimely killed by a rash act, are not necessarily impelled by suicidal motives.
5. Delirium is of a restless and distressing character.
6. False impressions received during delirium may be retained after recovery of consciousness.
7. After a severe attack no bad sequelæ need follow; the general health may improve, and the mind, even after prolonged unconsciousness and evidence of great disturbance, may regain its usual powers.
8. Typhoid fever is not really communicable from one person to another.—*Columbus Med. Journal.*

Typhoid Fever—Its Antipyretic Treatment.

Dr. AUSTIN FLINT (*Medical News*), concludes a lecture on this subject as follows:

1. That by the employment of cold water externally in cases of typhoid fever, the temperature of the body may, after a variable time of the continuance

of the employment, be reduced to 102° or lower.

2. After a period varying very much in different cases, and, also, at different times in the same case, the temperature, as a rule, again rises as high as, or higher than, before the reduction.

3. Repeating the employment of cold as often as the axillary temperature exceeds 103° , the number of repetitions required in different cases is extremely variable.

4. The sponge bath and the wet sheet with sprinkling may be employed to the exclusion of the bath-tub in the antipyretic treatment in cases of typhoid fever as well as of other febrile diseases.

5. These modes of employing cold water may be continued sufficiently long for the reduction of temperature to 102° or lower, and repeated as often as may be required, without risk of any immediate injury, and the study of these cases furnishes no ground for supposing that a liability to complications or accidents is thereby increased.

6. Reduction of temperature by these modes as often as it rises, in the axilla, above 103° , improves the condition of the patient. The cases now studied do not afford proof either that the fatality of typhoid fever, or that its duration is thereby diminished. The study of these cases, however, renders it possible that this proof would be afforded by a larger collection of cases.

During the period that the cases now studied were treated, seven hospital cases were recorded in which antipyretic treatment was not employed. In most of these cases the temperature did not rise above 103° , and it was for this reason that the treatment was not employed. Of these seven cases three were fatal, but I need not say that it would be unfair to draw any deduction from the contrast as regards the proportionate

number of fatal cases. It is well known that, in general, resistance, toleration and recuperation are not as well exemplified within as outside of hospitals. Moreover, in cases of typhoid fever, patients are not admitted into hospital until some days after the commencement of the disease. The clinical test of therapeutical measures, as far as fatality is concerned, is therefore best afforded by the study of cases in private practice.

7. The results of the analysis of these cases, although not sustaining the statements of Liebermeister and others respecting the controlling influence of the employment of cold externally in cases of typhoid fever, yet not only show this method of antipyretic treatment to be safe, but afford encouragement to employ it with the expectation of diminishing the severity of the disease and its danger to life.

Rule for Phenic Acid Medication in Typhoid Fever.

In order to gain all the good possible from phenic acid, it is absolutely necessary to begin with it at the very commencement of the disease and to keep up large doses. We must not lose sight of the fact that the drug will be the more powerful against the typhoid infection the nearer we approach to the period of the birth of the disease. Furthermore, it is necessary to mention again the fact that this medicament needs to be used with prudence and that although large doses may be well born in the immediate present, they nevertheless exercise a very deleterious influence after a time. The mortality in the army from typhoid fever is, according to L. Collin, 21 per cent. Our statistics show a mortality of 4.9 per cent.; those of Claudot 11.6 per cent., those of Desplats 19.4. If the statistics of Claudot

and Desplats are inferior to ours, the cause must be sought for in the method of administration. Under our instruction the maximum dose never in any case exceeded four grammes a day, on account of the one gramme by injection. The dose of three grammes we have always found sufficient to conquer in all cases even the most grave. We would not hesitate to advance the dose to four grammes in cases that might be exceptionally rebellious. Desplats gives as much as twelve to fourteen grammes per diem. This is a dangerous procedure and exposes the patient to the danger of losing all the benefit of the treatment. These immense doses favor the development of exceeding low temperatures, of phenic cachexia, and of visceral congestions. If perchance the patient escapes the malady he will run a great risk of succumbing to the treatment. There is no doubt in my mind that the unfavorable statistics of Desplats are due to the enormous doses which he used. As for Claudot we censure him less for the intemperance of his dosing, as he never exceeds six grammes in the day, than for the tardiness with which he commences the treatment. He does not commence to use the acid until the eleventh or twelfth day. This is entirely too late in our opinion. There is no call to give the typhoid infection time to develop and perfect itself. There is every reason to commence giving phenic acid injections as soon as the first suspicion of typhoid fever appears.

We attach the greatest importance to the tonic treatment, that we may, so to speak, keep abreast of the phenic medication and in some measure to antidote its action. The object of this precaution is to prevent the phenic cachexia or at least to moderate its effects. We therefore consider this a fundamental indication never to be neglected without

great danger to the patient. In the presence of the double menace, on the one hand typhoid fever, and on the other phenic cachexia, it is necessary that the vital forces of the patient be fostered with the greatest care in order that the disease and the medicine may both be resisted. Otherwise the patient succumbs to an extreme debility such as we have conclusive proof of outside of our practice, and sinks into a general feebleness, a condition which is particularly predisposing to visceral congestions and degenerations.

CONCLUSIONS.

From the clinical studies which we have made upon phenic acid medication, we draw the following conclusions:

1. Phenic acid does not act simply as an antipyretic in typhoid fever; it exerts a further influence on this affection at once antizymotic and curative.

2. The dose of phenic acid to be given in injections should never exceed four grammes per diem. Doses of twelve to fourteen grammes administered by Desplats, are enormous and harmful from the secondary effects.

3. Phenic medication is subject to secondary accidents, of which the most frequent and dangerous are pulmonary congestion and phenic cachexia. Convalescence is a period fraught with serious dangers to patients. They should be kept under the strictest surveillance.

4. Of all the known means of medication used in practice up to the present day, phenic acid treatment furnishes statistics of the most cures. We must here make a reserve in favor of cold baths, as those using them claim great advantages and even a quasi-infallibility. We have not had enough experience with the method of Brand to draw a comparison between it and phenic acid treatment.

5. Injections of phenic acid by their

ease and simplicity in administration furnish the best treatment for typhoid fever in armies on campaign when cold baths cannot be administered.

6. Tonic treatment should always be associated with phenic acid treatment.

We cannot close this paper without the following remarks: Typhoid fever is one of the most deadly maladies both in the civil population and in the army. This being the case, the treatment of this redoubtable affection should engage the most earnest attention and study of the physician. After having sought out the best prophylactic measures to prevent the development of typhoid fever, he should endeavor to discover the best means to combat it when he has failed to prevent it. We have faith in the anti-typhoid action of injections of phenic acid; and if, as we have the firm conviction, our experience shall be repeated on the continent, phenic acid, after having been recognized by surgery, shall also be recognized by medicine.

Peculiarities of Tuberculosis.

In the *Medical and Surgical Reporter* Dr. F. W. VOGEL explains some of the peculiarities of tuberculosis by the parasitic nature of this disease. Since the careful and extensive researches of Robert Koch have beyond doubt established the parasitic nature of tuberculosis, a good many phenomena of this terrible disease, hitherto unexplained, have become easy to understand. Tuberculosis, according to Koch, depends upon the presence in the body of rod-like bacteria, which are found in every case of phthisis, acute miliary tuberculosis, cheesy pneumonia of cattle, and sometimes in scrofulous affections, especially enlarged lymph nodes. This slender bacillus, pointed at both ends, the length of which varies from one-quarter to one-

half the diameter of a red blood corpuscle, is about five times as long as thick, and often shows four or five oval spores evenly distributed over its entire length. This bacillus, which absorbs methylene-blue but rejects brown aniline dyes, thus differing from all other bacteria known, is a true parasite of the animal body, flourishing only at temperatures furnished by its living abode, and becomes totally inactive at the ordinary temperature of our climate. Fortunately for mankind it multiplies very slowly, requiring nearly a week to proliferate much under the most favorable circumstances, so that it has no footing upon wounds of the outer surface, like other quickly developing organisms, but is washed away by the secretions before it has had chance to multiply. Even in the sheltered air passages, where it generally makes its first appearance, unless finding its soil prepared by previous inflammatory processes, loss of epithelium, etc., it seems entirely innocuous, being readily removed with the secretions before it has had time to take root. When it once has a firm footing, its local extension is still slow, because the bacillus has no movement of its own, and in order to reach the other parts it must be carried thither by the lymphoid cells. If, however, the bacilli reach the lymph channels, they are carried greater distances, successively infecting the whole track of a lymph vessel, until stored up in the filter of the nearest lymph node. The matter becomes very serious when numbers of them reach the blood currents in the veins, when they become disseminated through numerous internal organs, and acute miliary tuberculosis will be the result. The anatomy of a tubercle is easily explained now also; a bacillus settles in a tissue, irritates and causes a small cell infiltration around it; those cells nearest the parasite grow up

to fibroblasts (epithelioid cells) which, closely pressing upon each other, coalesce and form the giant cell, so often found in the centre of miliary tubercles, harboring one or several bacilli. This giant cell is again surrounded by embryonic cells, some of which are growing up into epithelioid cells. Since no blood vessels form, the centre of the tubercle undergoes fatty degeneration as soon as the growth spreading in the periphery has become extensive enough to take up all the nutriment supplied by the nearest vessels. A number of bacilli appear to die within the cells, which gradually shrink up into a cheesy mass, but others are taken up with particles of detritus by lymphoid cells, and are transported into the immediate vicinity where they begin slowly to proliferate again, giving rise to a fresh tubercle, when the process is repeated over again, adding to the central destruction as well as to the peripheral proliferation.

As may be inferred from this, the bacilli are found in greatest numbers where the process is in the act of spreading; where the latter is stationary they are difficult to find. How do the bacilli enter the system? Koch found that sputa of phthisical patients always contained bacilli; in fact, that the grumous masses so generally present in all vomicae entirely consisted of agglomerations of these parasites. The drying of a sputum does not rob the bacillus of its life; sputa dried for eight weeks and injected into guinea pigs, produced acute miliary tuberculosis in every instance. The dry sputum upon the floor is ground into dust, the bacilli adhering to some particle of the latter enter the lungs with the air we breathe and are arrested upon some prominent spot of the mucous membrane which lies opposite the air current, especially the ridges of the alveolar septa. But there are other chan-

nels. Pleuro-pneumonia of cattle being identical with tuberculosis, the bacillus may be introduced into our alimentary canal with the meat or milk of cattle suffering from this disease. There is one point which might be urged against the conclusiveness of Koch's observations. We mean the hereditary acquisition of consumption. Still, this can be explained very easily. Judging from analogy with syphilis, the twin brother of tuberculosis, direct transmission of the disease germ is possible, also that the disease may remain latent unless the germs are so numerous as to overwhelm the resistance of the vigorous functions of the young cells of childhood. Furthermore, numbers of them are easily stored away in some lymph-node, where they are kept from doing general mischief for a time. Again, we must keep in mind that in cases where direct transmission of the disease germ has not taken place, the direct contagiousness and infectiousness of the bacillus comes into free play, the children being obliged to inhale constantly the infected air of their home, or ingest the parasite with the mother's milk. The practical results obtained from Koch's valuable paper may be summed up as follows: All sputa from phthisical patients are to be disinfected immediately; also the clothing, bedding, etc., before used by other people. Phthisical mothers must not nurse their infants. Scrofulous, infiltrated glands ought to be excised. Meat and milk from cattle which have suffered from pleuro-pneumonia must not be allowed to enter our system. Antiseptic treatment, perseveringly and vigorously carried out, is the only rational treatment for consumption. Carbolic acid inhalations through the nasal respirator local treatment of tubercular ulcers, fungus arthritides, etc., with iodoform, have already given great results,

the latter remedy being preferable in places where the drug can remain undisturbed for a longer time.—*Chic. Med. Review.*

Sodium Salicylate in Acute Rheumatism.

After a prolonged trial of salicylate of soda in the treatment of acute rheumatism, the profession has come to regard it as one of the most valuable remedies yet introduced into the materia medica. As to its *modus operandi*, observers are by no means agreed, although many believe that its action is as nearly specific as is the action of quinine in intermittent fever. In an article in the *Practitioner* for June, '82, Dr. Clouston says that its effect on the duration of the disease is most marked, for in 63 per cent. of the cases the acute stage did not last over three days; the pain was relieved in a few hours, and the remainder of the sickness was free from severe symptoms. He publishes a table showing the results obtained by other observers, nearly all of whom agree as to the value of this remedy, and also that the tendency to complication is diminished in proportion to the shortening of the acute stage, and that relapses are less frequent. Dr. Clouston believes that success in the treatment depends, to a considerable extent, upon the quantity administered at each dose, for if it be too small the acute stage will not be cut short, or the pain relieved, and if too large, headache or other uncomfortable symptoms will be produced. The dose recommended as the best in the majority of cases, is 10 grains every hour until the symptoms are relieved. If, from any cause, he finds it necessary to suspend the sodium salicylate, he administers salicine in doses of 15 or 20 grains three times a day, partly with a view to its tonic effect on the system, and partly from its well-known efficacy

in the treatment of the disease under consideration, salicine being converted into salicylic acid in the system. Dr. Clouston gives an epitome of 27 cases treated by him, from which the following conclusions may be drawn: viz., that the best results are obtained by early treatment, and that after the acute symptoms have disappeared, the medicine should be discontinued gradually, and if any signs of a relapse appear, it should be immediately resumed. We have used salicylate of soda for several years, both in hospital and private practice, and can fully endorse Dr. Clouston's conclusions. The prescription we generally use is as follows:

R. Acid salicyl., ʒ iij; sodæ carb., ʒ iss; syr. limonis, ʒ j; aquæ cinnam., ad. ʒ viii. M.

Sig.—A tablespoonful every two hours.

Some physicians give as high as 20 grains every two hours, but there is danger of sudden collapse from large doses of this remedy. Dr. Brinton (*Medical and Surgical Reporter*) administers it in 20 grain doses every two hours until the pulse is reduced, and states that in 20 grain doses there is no danger of collapse so long as the pulse does not fall below 84. He combines it with liq. ammonia acetatis and thinks it acts better than when given alone.—

Editorial Canada Lancet.

DISEASES OF THE NERVOUS SYSTEM.

Peculiar Attacks in a Case of Locomotor Ataxis.

Drs. RAYMOND and OULMOUNT observed peculiar attacks in a patient suffering from tabes. Dr. Bernhardt gives us, in the *Centreb. f. d. Med. Wis.*, 9, 1882, p. 160, the following description:

The patient awakened suddenly, usu-

ally in the night, with a violent desire to micturate, but passed a few drops only; a most intense pain seemed to tear his urethra apart. This paroxysm lasted from one to two minutes and returned every fifteen to thirty minutes. The duration of the whole seizure was generally from ten to twelve hours; toward the close, the poor sufferer passed a few drops of pure blood; the attacks then ceased, but nearly the whole of the following day the urine was somewhat bloody.

Such crises usually happened then, when the lancinating pains in the lower extremities had been of a specially severe character. If the patient continues in the recumbent position, the attacks are somewhat milder than when he is restless. Raymond and Oulmount remark that one should not forget to look for stone in the bladder in such cases, which the blood seemed to indicate. In this case no stone could be found.—*Med. and Surg. Reporter.*

Condition of the Cutaneous Nerves in Locomotor Ataxia.

M. DÉJÉRNIE recently announced to the Paris Société de Biologie that the pathological condition presented by the cutaneous sensory nerves, in ataxic patients, is, essentially, a peripheral neuritis. This statement M. Déjérnie bases upon the fact that, in a case recently observed by himself, the spinal ganglia and the posterior roots below the latter were perfectly normal in appearance, while the cutaneous nerves were the seat of a neuritis.—*Progrès Médical.*

Nerve-Stretching for Locomotor Ataxy.

Dr. CHARLTON BASTIAN has recently delivered a clinical lecture at University College, on a marked case of locomotor ataxy, the symptoms of which he de-

scribed very minutely. The patient was about forty years old, there was wasting of the muscles of the extremities, especially in the left leg and thigh; at length the movements of his legs became slow and jerky, after walking a few yards he would become exhausted and his legs would double up under him. Mr. Marshall cut down on the great sciatic nerve on the middle third of the right thigh and stretched it with his finger, pulling it twice upwards from below, thence twice downwards from above; antiseptic precautions were employed. About five weeks later, the right lower limb having markedly improved, whilst the left remained as it was before the right sciatic nerve had been stretched, Mr. Marshall operated on the left sciatic in the same manner. Troublesome diarrhoea followed, but seven weeks later, when the patient tried to walk, his gait was found to be much better, and tactile sensibility, previously impaired in the lower extremities, had become perfect. The first operation was followed, in seven days, by the disappearance of a constant aching pain in the hypogastrium, which did not return, though slight pain was felt in the lower part of the chest. In a less advanced case treated in the same manner the improvement was but slight. The wounds, in these cases, were slow to heal. Dr. Bastian does not attempt to explain the mode in which nerve-stretching acts, but if it is found to do good, it should be practised. The manner by which many drugs act specifically on many morbid processes is quite unknown, yet that is no reason for not continuing their use when they are known to be beneficial in disease, and the same principle now applies to nerve-stretching.—*British Medical Journal.*

Case of Progressive Muscular Atrophy.

Dr. T. B. VAN ALSTYNE (*Med. Annals*): E. McC., female, aged 19, dress-maker, was admitted to Albany Hospital February 26, 1879, giving the following history: She was married at the age of 14. Four years ago she became pregnant, but miscarried during second month, as the result of a fall down stairs. Has complained more or less ever since of nausea and pains in stomach, abdomen, head and eyes. Menstruation was regular until three months ago, since when there has been no flow, but the menstrual period has been marked by pains in back, thighs and feet. In July, 1878, she had metritis.

In the latter part of August, 1878, had pain in left arm, coming on about 5 P.M., and not ceasing until the following noon. These pains continued until the middle of September, when they disappeared, and it was found that the arm was very much wasted and almost useless. Early in October she lost the use of the right arm without the occurrence of pain. Pains between the shoulders and along the sides and thighs were now complained of. She suffered from dyspnoea and walked only with great difficulty. There was formication and muscular twitching all over the body and head, the latter being hot and tender to the touch. In January, 1879, the pains were confined to the feet and legs, but after a few weeks they disappeared, only to return for short periods. On admission, in addition to these occasionally occurring pains, which were very severe, there was headache, transient oedema of face and posterior aspect of forearms, and constipation, due to the use of morphia for relief of pain. Is very much emaciated. Muscles generally, but especially the extensors, are greatly atrophied. Is unable to

move any part of body except the head, which she can turn slightly from side to side on pillow, and fingers and toes, which she can move slightly. Prof. E. R. Hun assumed charge of the case, diagnosed progressive muscular atrophy, and prescribed treatment as follows: *R.* Ext. aconit. fld., 3 ss.; ext. gelsemii fld., 3 i; sodii salicylat., 3 ii.; infus. gent. co. ad., 3 iv.—*M.* Sig.: A teaspoonful every six hours. Faradization of muscles generally to be made twice a day, each sitting to last fifteen minutes; Stokes' liniment (*R.* Ol. terebinth., 3 iii.; acid acetic, 3 v.; aquæ rosæ, 3 iiss.; ess. limonis, 3 iv.; ovi vitell. No. i. *M.*) to be applied with friction to the surface. After three weeks the internal treatment was discontinued on account of the gastric disturbance which it occasioned. The faradization was very thoroughly applied, and improvement was rapid. April 15, 1879, patient is able to raise herself in bed, first on her elbow, and finally to a sitting posture. April 28, she is able with very little assistance to walk across the room. The muscles are becoming more prominent, but the extensors are still very much wasted. June 15, is able to be around the ward dressed the greater part of the day. General condition good and strength increasing daily. June 29, 1879, discharged cured. In January, 1880, was seen by Dr. Sheldon Voorhees, of the resident staff of the hospital, and reported by him to have had no relapse.

Practical Notes on Neuralgia and its Treatment.

There exists no better established nor more important fact than that neuralgia is a disease arising when the body is in a state of general debility. This is now more generally recognized than formerly, when pain was too often regarded as the symptom of what was termed

"sthenic inflammation," to be energetically treated by low diet and repleting remedies.

As this disease is frequently mistaken for rheumatism, gout, spinal irritation, &c., and *vice versa*, it may be well to name some of the leading features of a typical case of neuralgia. 1. It occurs when general debility exists, is increased by fatigue, mental or bodily, but relieved by food and sometimes by stimulants. 2. The pain, which is sudden, darting and excruciating, exhibits remarkable intermissions, especially in the early stages of the complaint, and the constitutional disturbance is slight (temperature, pulse, &c., frequently normal). 3. It is usually unilateral. 4. As the disease advances tender spots (points douloureux) are formed in the course of the affected nerves.

That debility is a prime factor in neuralgia we have but to call to our remembrance cases which constantly appear. The overworked, anæmic, badly fed girl, suffering from neuralgia of the fifth, the anxious, struggling man in the early years of professional life or business, the married woman weakened by child bearing or over zealous in domestic cares, and the neuralgia of declining years, degeneration having set in, nutrition being defective. In our diagnosis we are assisted by the family history of the case, whether nervous disease in any of its varied forms has existed.

The treatment should be directed in every case toward improving the general health. Nutrition must be improved by very nourishing food, well masticated, and if stimulants are prescribed they should be given with food; pure air night and day; great cleanliness, and the use of sponging with sea salt and water. Cod liver oil and cream are of service, given after meals. Quinine in facial neuralgias, and also chloride of

ammonium; arsenic in cases of angina pectoris; iron and strychnine in anæmic states. Bromide of potassium is useful in mild cases, where the pain is not severe, but a general nervous condition exists, with restless irritability. The subcutaneous injection of morphia, beginning with one-sixth of a grain, is the most speedy and useful remedy we possess, and is a curative agent; for it checks at once pain, and thus gives us the opportunity of carrying out all those constitutional measures for improving the general health, whilst it disturbs but little appetite and digestion, and with use a toleration is established, and appetite sometimes improved; for nothing is more apt to destroy appetite than the distress of severe pain. In chronic cases of neuralgia, a blister, not necessarily carried to the point of vesication, is often of the greatest possible service, and it is a treatment peculiarly adapted to old standing intractable cases.

Having sketched the mode of treatment it is unnecessary to give illustrations of the ordinary cases which constantly present themselves in hospital and private practice. I therefore select from my note book one of several successful cases where neuralgia has occurred in that period of life when a cure is rarely accomplished (some authorities say *never*)—the degenerative period.

In March, 1877, I saw, in consultation with Dr. Walker, of Wakefield, a lady aged seventy-six, who in early life had suffered severely from neuralgia of the stomach, which had been much aggravated by the treatment then in vogue of insufficient nutritive food and depleting remedies. This patient was seized with violent pain, affecting the nerves of the scalp, and which became so excruciating as to deprive her of sleep for many successive nights. She became delirious

in consequence, and we decided to inject one-quarter of a grain of morphia. This gave prompt relief and procured sleep. She was ordered turtle soup, oysters, and an exceedingly nutritious dietary. She was well supplied with food at night also, which invariably relieved the pain. A mixture, containing half-drachm doses of aromatic spirit of ammonia and fifteen minims of tincture of nux vomica, seemed greatly to improve the appetite, which became prodigious and surprising. The tendency to degenerate was kept prominently in view, pure air was freely supplied in the bedroom, and every other measure taken to improve nutrition and the general health. As a local application, the chloroform liniment with tincture of opium relieved pain, and as soon as the case became chronic, the hair was cut closely and blistering fluid applied to the tender spots, which were well developed in this case; multiple abscesses formed, and were frequently opened by Dr. Walker. The old lady, after an illness of three months' severe suffering, recovered perfectly, left Wakefield for Harrogate, and is now (1882) in fair health, having had no return whatever of her former complaint. Her body is feeble, but her mind extraordinarily clear and bright for a lady who has passed her eighty-first year.—*London Lancet*.

Neuralgia.

The following prescription is recommended by J. ASHBURTON THOMPSON, in Neuralgia:

R. Phosphori, gr. j.; alcohol, 3 v.; glycerini, 3 iss.; spts. vin. rectificat., 3 ij.; spts. menth. pip., 3 ss.

Dissolve the phosphorus in the alcohol by the aid of heat; warm together the glycerine and wine, mix while hot and add the peppermint on cooling.—*Med. Gazette*.

DIGESTIVE TRACT.

American Dyspepsia.

In the *Boston Medical and Surgical Journal*, Dr. JAMES H. ROBBINS takes the ground that the prevalence of dyspepsia among us is due less to improper food, badly prepared, to haste in eating, or to excessive eating, than to the fact that we nearly all are the possessors, either by inheritance or acquirement, of imperfect nervous organizations that are consequently unable to lend their aid to digestion as they should; for this reason but few of us are able to digest enough food for our bodily repair; hence we experience the sensation of having over-eaten, when in reality we have not had enough. The author says:

"Such causes operate with special power upon us of the present generation of the Anglo-Saxon race, whose ancestors came to this country several generations ago, for the reason that from these ancestors we inherit nervous systems of impaired vigor. Our parents and grandparents were so strenuously engaged in an arduous, ambitious and competitive endeavor, amid the rapidly changing conditions of life in a new country, to secure competency and respectable social position, that they expended, to a great degree, their own vital powers, and have accordingly transmitted to their children delicate and neurotic constitutions. If it is granted that we inherit a diminished vitality, it is easy to see how ingeniously the pressure, the wear and tear, the strain, the excitement, the hurry and worry incident to this breathless, bustling life of ours, affect the nervous system. It is also evident that impairment of digestion and mal-nutrition must be the certain result of such a condition of things."

This deterioration of the nervous system is fostered and increased by our

faulty methods of raising children and our own erroneous style of living when we reach maturity. The evident remedy is to be found in an elevation of the tone of the nervous system. Whether this theory be true or not, it is a very charming one, and would certainly seem to account for much of the dyspepsia that renders so many persons miserable.

Intestinal Obstruction Relieved by Massage.

Dr. BITTERLIN reports a case of intestinal occlusion accompanied with much pain, vomiting of fecaloid matter, hiccough continuing in spite of treatment for eight days, finally relieved by kneading and malaxation of the belly. The manipulation was very painful. Some instants after, violent colic came on and gurglings, the bowels shortly afterwards moved and the patient recovered. Dr. Bitterlin mentions a second case in which he was called in consultation, where the same treatment was followed by the same happy results.—*L'Union Medical.*

Pruritus Ani.

Dr. H. K. STEELE (*Cin. Lancet and Clinic*), recommends the following ointment as almost a specific for pruritus vulvae or pruritus ani: \mathcal{R} . Quiniæ sulphatis, 3 i; adipis, q. s. ut. ft. ungt. M. Sig.—Apply freely p. r. u.

Alcohol at Meals.

Before quitting the subject of dining, it must be said that, after all, those who drink water with that meal probably enjoy food more than those who drink wine. They have generally better appetite and digestion, and they certainly preserve an appreciative palate longer than wine-drinkers.—*Sir Henry Thompson.*

Hypodermic Administration of Cathartics.

Dr. A. HILLER, of Berlin, in the *Zeitschrift für Klinische Medizin*, iv., 40.

The author has reviewed the experiments that have heretofore been made in the way of injecting into the subcutaneous connective tissue medicine intended to produce catharsis, and has at the same time somewhat extended the list. He has, for a number of years, upon merely theoretical grounds, expressed his belief in the possibility of producing such effects and has maintained the opinion that it was only a question of time when appropriate remedies would be found for this purpose. But, the discovery of a suitable remedy has until now, evaded all pharmaceutical research, and among all those that have been proposed there is not one that answers all the requirements of a hypodermic cathartic remedy.

Aloin, which has been the most universally used in experiments of this kind gives, according to the manner of administration, a varied action. Hiller observed, after the injection of from fifteen centigrammes to two decigrams, a copious, mushy discharge in from four to six hours after administration. In a brief review of experiments by Kohn, not referred to by the author, aloin was administered subcutaneously in the dose of eight decigrams without producing catharsis.

The colocynthus purum prepared by Merck of Darmstedt, a light, grayish-yellow powder of a bitter taste, administered internally or subcutaneously in the dose of five to ten milligrams produces watery stools with moderate tormina. A solution in alcohol, glycerine and water is the best adapted to hypodermic medication. The injection is very painful. There is also a resinoid substance called citrullin, extracted from the colocynth fruit, insoluble in

water, which when taken internally in the dose of five milligrammes to one centigramme, or if administered hypodermically in the same dose, dissolved in equal parts of alcohol, water and glycerine, will produce the desired effect, but it produces also severe pain accompanied by œdema and redness of the skin. The action of colocynth and citrullin is also manifested by the officinal extract of colocynth. A dose of fifteen milligrammes to six centigrammes injected under the skin produce not only diarrhetic evacuations, but also pain and œdema.

The substances thus far named, together with a small quantity of fluid produce diarrhœa in from a half to one hour.

Experiments with cathartic acid from senna show that this remedy, rather freely soluble in water, will produce catharsis if taken internally in the dose of two or three decigrammes dissolved in water and glycerine. Administered subcutaneously, it produces painful inflammation of the skin with a tendency to the formation of sloughs. If, however, the solution be made alkaline, this effect is not produced, and furthermore, one decigramme will occasion copious evacuations, in eight to twelve hours.

The extract of elaterium, as well as the pure elacterin, is too often ineffective, and frequently it is for other reasons inapplicable.

Leptandrin, a glucocide of leptandra virginiana, internally, in the dose of five decigrammes, gently stimulates peristalsis without producing diarrhœa.

Euonymin, the glucocide of euonymus, atropurpurea internally (one to two decigrammes) acts mildly. In obstinate constipation, a dose of three decigrammes or more will be found effective.

Baptisin, a glucocide of baptisin tinctoria, has to be given internally in the

dose of three or four decigrammes to produce mild catharsis in four or six hours.

The three latter remedies have been for a number of years employed in America and their therapeutical value well studied.—*Deutsche Medizinal Zeitung*.

Gastric Digestion.

The *American Chemical Journal* contains a review of an exhaustive study of gastric digestion made by SCHMIDT MULHEIM, under the direction of C. Ludwig, of Leipzig, and published in Du Bois Raymond's *Archiv. of Physiol.* As a result of these investigations, it is found that gastric juice digestion continues for a much longer time than is generally supposed. Even after nine hours' digestion, unaltered food is still found in the stomach, food, too, which, from its finely divided condition and by boiling, has been changed to the easiest state of digestibility possible. Only after twelve hours can gastric digestion be considered as finished. It also appears that in the products formed during digestion the peptones at all times exceed in amount the dissolved albumen, and that the relative proportion of these two products is not materially altered during the digestive process. The total quantity of peptones and dissolved albumen, moreover, remains about the same during the whole time, which shows that after the formation of a certain quantity of these products their removal keeps pace with their further production, and thus the equilibrium is preserved. In intestinal digestion it is found that the contents of the intestine have at all times an acid reaction. This was true both with the liquid contents of the upper intestines and the semi-solid materials in the lower ones. This result, which is contradictory to

the prevalent idea that the three alkaline digestive fluids—bile, pancreatic and intestinal juices—are sufficiently strong to render the entire contents of the intestinal canal alkaline, has an important bearing in pancreatic digestion. While in alkaline digestive fluids putrefaction soon shows itself with simultaneous formation of crystalline decomposition products, together with large quantities of indol, the digestion of albumen by an acid pancreatic juice is more analogous to a pure digestive process, since it is well known that pepsin is powerless in an alkaline medium.—*Chic. Med. Review.*

Boiled Milk in Summer Complaints.

Dr. H. V. SWERINGEN writes to the Cincinnati *Lancet and Clinic*, emphatically condemning the advice, so often given, to boil the milk administered to children suffering from summer complaints. He objects to this procedure because boiling will coagulate the albumen, thus rendering it very difficult of digestion. He is right. *Boiled* milk is utterly unfit for children; but since the majority of children will refuse milk when it comes cold out of the refrigerator, it will be well to place the cup or bottle containing the milk into a pan of warm water for a few minutes; this will remove the chill without coagulating the albumen.—*Med. and Surg. Reporter.*

DISEASES OF THE CIRCULATORY ORGANS.

Diastolic Heart-Murmur without Valvular Lesion.

Dr. N. WEISS (*Wiener Medicinische Wochenschrift*), reports the case of a man in whom during life a diastolic murmur was heard at the apex. The murmur was heard continuously for four weeks before death. The other heart-sounds were normal with the ex-

ception of the second sound at the aortic valve, which was accentuated. The patient died of cancer of the pylorus. At the autopsy there was found a patch of recent endocarditis on the auricular surface of the aortic half of the bicuspid valve. There were also traces of old endocarditis at the bicuspid with consecutive valvular aneurism; endarteritis deformans of the aorta, with dilatation of the ascending portion; eccentric hypertrophy of the left ventricle; commencing pericarditis with milk spots at the apex and over the right ventricle. The pericarditis could not have caused the murmur, and there is hardly room to doubt that it was connected with the changes found at the mitral valve. The little aneurismal pouches on this valve were turned with their cups facing the auricle, and were also slightly roughened. There was, however, no disturbance of function caused by these changes, nor was there any stenosis of the venous opening into the auricle. Here, then, there was no valvular lesion in the ordinary clinical sense of the term, yet there was a persistent diastolic murmur at the mitral opening observed during several weeks preceding death.—*Med. Record.*

Symptoms Simulating those of Angina Pectoris, Arising under the Local Application of Ergotin.

By T. NESLEY MILLS, M.A., M.D., L.R.C.P., Eng.:

The Rev. J. C., aged thirty-six, came under my care for a growth on the left vocal cord. After making trial of the usual remedies for diminishing such growths, it occurred to me to try the effect of applications of ergotin. To one ounce of glycerin one dram of tincture of iodine and fifteen grains of ergotin (increased on March 24th to thirty grains) were added. This was freely applied (with a laryngeal brush dipped

in the mixture four or five times) every morning. This treatment was begun on March 20th, and continued till March 26th, without any special developments. That day being Sunday, the patient did not visit me; but on the following morning he made complaint of having had an attack of pain in the cardiac region of the most alarming and agonizing character. It had then almost or quite disappeared, but had been severe after the onset for three or four hours. He stated that the action of the heart was rapid "throbbing," and that there seemed to be interference with respiration. He also made special mention of a sensation of coldness around the heart. An examination of the chest revealed no disease that could explain these symptoms. No special complaint was made in the interval up to April 1st of anything except a marked "oppression on the chest," which the patient attributed to a cold.

On the evening of April 1st the patient called to state that he was suffering from peculiar symptoms. There was pain extending down the neck, along the inner border of the sterno-cleido-mastoid muscle, outward beneath the clavicle, and down the arm to the finger-tips; there was numbness and partial loss of power in the arm and hand. These symptoms were confined entirely to the left side, and passed off gradually within twenty-four hours. The ergotin being now suspected to be the cause of these disturbances, it was discontinued; though its use may have been beneficial as far as the growth was concerned, for on April 6th a portion of it was coughed up. I could discover no pallor of the arm affected, and no difference in the pulse of that side. Unless certain of these symptoms are to be referred solely to the use of the ergotin, such as coldness in the cardiac region, and numbness, etc., of

the arm and hand, it seems difficult to explain them.

These are symptoms almost peculiar to angina pectoris; and this case seems to confirm, in a most remarkable manner, Dr. Lauder Brunton's theory as to the causation of angina pectoris—at least one of its possible modes of causation. This man had had no such symptom at any period of his life previously, and the most careful examination revealed no aneurism or any form of cardiac disease. Moreover, there were no such symptoms while under my observation prior or subsequent to the use of ergot.—*Brit. Med. Jour.*

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DISEASES OF THE RESPIRATORY ORGANS.

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On Diet in Cases of Asthma and Bronchitis.

Dr. JOHN C. THOROWGOOD (*Med. Press and Circular*), after referring to the danger of sudden death following a full meal in persons suffering with bronchitis and emphysema of the lungs with some cardiac dilatation, says:

The late Mr. Pridham, of Barnstaple, acquired great celebrity for curing bronchitis and bronchial asthma by diet. The great secret of this diet-cure was judiciously starving the patient for a time. A large number of persons afflicted with chronic bronchitis and asthma are hearty feeders, and have to submit to some annoyance by being often and inopportunistly complimented by their friends, and told how well they are looking, just at the time, perhaps, when a congested liver, plethoric abdomen and constipated bowels are sorely adding to the difficulties in the breathing apparatus. Expectorants for the cough, and spirits and water, or port wine, to strengthen the palpitating and oppressed heart, are means not likely to improve

matters, and the patient comes to regard his case as a severe and intractable one. These are, however, just the cases in which much good may be done simply by dietetic means and attention to stomach and liver, while the heart and lungs are left to take care of themselves.

The great principle in regard to diet seems to me to be to avoid bulk or mass of food. Often the patient shows a large, thick, atonic tongue, indicative of a torpid condition of stomach, so that the organ will receive a large amount of simple food without resenting it at the time, though acidity and heartburn may come on one or two hours after a heavy meal. The patient then must not, under the impression that he is likely to die from weakness, eat as much as ever he can at every meal, but must make up his mind to rise from the table capable of taking more, but wisely abstaining from so doing, and the food he does take should be nutritious without being bulky. A lightly-boiled egg, the wing of a chicken, or some fish, with one cup of tea, coffee, or cocoa, and dry toast with butter, will form three alternations of breakfast fare. At dinner soups should be avoided, as tending to cause distension of stomach. Vegetables must be taken sparingly. All malt liquors, with pastry and cheese and dessert, should be rigidly eschewed; and for drink, claret with water, or lemon-juice and water, may be allowed. Effervescing drinks of all kinds are not to be commended for habitual use, though sometimes after dinner an effervescing water, slowly taken, acts as a stimulant to the stomach, and so may promote digestion. If the dinner be taken at midday, then before going to bed a small meal of bread and meat, or of rusks scalded with hot water and mixed with milk, may be taken; but a

full meal at night will press heavily on the diaphragm, and cause great distress and discomfort.

By this arrangement of diet we keep up nutrition, while we avoid overloading the stomach and so oppressing the diaphragm. The heart and lungs are enabled to work freely, and danger of sudden stoppage of the first-named organ is put at a distance.

Under circumstances of extra fatigue it is well before commencing a meal to take a wineglass of sherry, but never should alcohol in any form be taken without some kind of food. Large quantities of liquid in the way of drinks of all kinds with the meals are bad; and one glass of wine, with or without water added, will prevent that great craving for copious libations of non-alcoholic liquors with the meals which appears to affect some of those whose practice it is totally to abstain from all forms of alcohol.

The venous congestion of the mucous surfaces of the alimentary canal prevents ready absorption of watery fluids, and becomes a cause of great oppression. To relieve this state, I do not know any plan of treatment better than the persistent use of small doses of some saline laxative, such as sulphate of magnesia, Carlsbad salt, or acid tartrate of potash. At first there may be some discomfort and increase of venous plethora from the use of these remedies, but as their effect in the way of moderate purgation becomes manifest this will pass away, and the amount of benefit that will result be in every way satisfactory.—*Louisville Med. News.*

Phthisis.

DA COSTA considers ergotin the best remedy for the night-sweats of phthisis—two grains three or four times a day. It is less prompt than atropia, but it is free from any unpleasant effects, which the other is not.—*Maryland Med. Jour.*

M E D I C I N E .

CONSTITUTIONAL DISEASES.

Treatment of Typhoid Fever by Antiseptics, especially Carbolic and Salicylic Acids.

A communication of M. VULPIAN to the Academy upon the treatment of typhoid fever by salicylic acid is of the most interesting character. It is an accepted belief that typhoid fever is an infectious disease, like others, with a parasite in the blood which all efforts to overcome have heretofore been vain.

The treatment by quinine, formerly highly recommended by Bean, is now almost forgotten. Sulphate of quinine is, however, one of the most powerful antiseptics. Attention was again called to this fact last year by M. Hallopean. The phenic acid treatment has awakened an enthusiasm which to our mind seems excessive. Indeed, in a recent discussion before the *Société Médicale des hôpitaux*, we observed that now those who had most eagerly accepted the medication by carbolic acid had abandoned it on account of the dangers it involved. On this account M. Siredey, for example, announced that he no longer gave phenic injections except to modify the fetidity of the stools, and immediately after, having given a carbolic acid injection, he gave a large injection of water to cause its evacuation before its absorption. Carbolic acid intoxication is a dangerous phenomenon, and it has always been a matter of astonishment to surgeons to see physicians prescribing internally carbolic acid with an amazing liberality, while they, always on the lookout for absorption by the skin or by the surface of wounds, are constantly

busy with the inconveniences of this precious antiseptic.

I may add as a corollary that a number of times I have observed in patients treated medically with these poisons that it has been easy for me to recognize the symptoms at the outset, so familiar have I become by long experience with the action of phenic acid.

All are agreed, however, whether it is true that the acid lowers the temperature or not, that it modifies in no particular the progress of the disease.

M. Vulpian has experimented with other antiseptics, and has employed iodoform, salicylate of bismuth, boric acid and salicylic acid.

Iodoform, boric acid as much as 12 grammes a day, phenate of soda as much per diem as 9 grammes were given without result.

Salicylate of bismuth, 12 grammes a day, lowered the temperature, disinfected the stools, and brought about general improvement, but caused dyspnœa, nasal and intestinal hemorrhages.

M. Vulpian then gave salicylic acid in powder, adopting a very simple form of administration, 25 to 30 centigrammes in wafers every two hours up to 6 or 7 grammes in the twenty-four hours; each dose should be followed by the ingestion of a liquid, either water or wine. In general the medicine was well borne.

The only accident which seemed to him attributable to the salicylic acid was a little delirium. He met with neither dyspnœa nor hemorrhage. The result was a lowering of temperature as with phenic acid, but more persistent. The general condition was very favorably modified, but the duration of the sick-

ness did not seem to have been materially influenced. M. Vulpian concludes, then, that, without constituting a curative agent of typhoid fever, salicylic acid exercises upon the disease a moderating action of sufficient power to merit a place among the best modes of treatment. He asks the question whether this substance might not be employed as a prophylactic, and whether this substance, incapable of neutralizing the poison when once the system is invaded, will not act to ward it off. It is well known that a healthy man has very well borne 2 grammes of salicylic acid a day.

In the course of the discussion M. Bordeaudat appropriately called attention to turpentine, a very powerful antiseptic agent, very diffusible and unfortunately neglected in the midst of all these researches.

In conclusion, it is a question which remains to be studied. It is impossible to deny that antiseptics have accomplished something, and agreement upon this conclusion will certainly be reached, if it is not forgotten, that antiseptics have very different elective actions and act very differently upon the different micro-organisms. But at any rate, the reader will be struck by this proposition of salicylic acid administered daily as a prophylactic, when it is taken into consideration that it has only been a short time since the employment of this salt was condemned in unmeasured terms. Salicylic acid attacked us on every side, it was said; it is a most dangerous poison, and it endangered even when administered in the most insignificant doses. The wisest have always thought that there was a singular exaggeration upon this point, and that it was best to limit the employment of an article little enough objectionable, provided it was not ignorantly abused. — *Journal de*

Medicine et de Chirurgie Practique.—*Western Med. Reporter.*

Ergotine in Typhoid.

The Boston *Medical and Surgical Journal* says that the treatment of typhoid fever by the subcutaneous injection of ergotine, as recommended by Dr. DUBONÉ, continues to be noticed in *Le Journal de Medicine et Chirurgie*. The last case described is of a young woman, three to four months pregnant, in whom the treatment was begun on the eleventh day of the disease, when there was much tympanites, diarrhœa, bronchitis and dyspnœa, and when continuous delirium had given place to semi-coma. The morning temperature was 104° F. Ten centigrammes of ergotine were injected daily for six days. The first injection was followed by a copious general papular eruption, of the size of a millet seed. The temperature fell to 101.5° F., and did not again rise above 103 F. The other symptoms underwent corresponding amelioration, and the temperature became normal on the seventeenth day of the disease.—*Med. and Surg. Reporter.*

On the Continuous Inhalation of the Vapor of Slacking Lime in the Treatment of Membranous Laryngitis.

Dr. EUGENE F. CORDELL (*Maryland Med. Journal*): The doctor, after giving the various methods and remedies employed in this disease, concludes his article as follows:

The following experience occurred to me: In a family nearly related to myself, a child, aged three and one-third years, was attacked with diphtheritic laryngitis (a typical case of so-called "true" croup), and died after about thirty-six hours' illness, notwithstanding a resort to tracheotomy. No steam or lime was used. Some years after another child

in the same family, aged twenty months, was attacked with identical symptoms, and upon examining the throat a membranous deposit was found covering the left side of the fauces. I determined at once upon the following plan, and put it into execution without delay: I procured two narrow pieces of board and fastened them in an upright position to the foot-posts of a double bed. Their tops were connected with each other, and also with the ends of the head-board of the bed, by means of rope; a piece of rope also extended from the centre of the head-board to the lower cross-rope. Over this rope-work arrangement I placed sheets, pinning them securely and forming a sort of tent about four feet in height and breadth, and six feet in length, and covered on all sides. The child and its mother (who was willing to submit to anything that promised to save the life of her little darling) were now placed in this tent and a vessel of water soon set to boiling within it. Into this boiling water every few minutes a lump of lime was thrown, and this was kept up faithfully day and night for five days. To secure a still greater effect, two basins were also placed inside the tent, in which lime was slacked from time to time. During this time the mother remained with her child, feeling, like myself, assured that safety depended upon the faithful execution of my orders. She did not, however, find it oppressive, although both herself and the little patient were constantly bathed in perspiration. She even recovered from an unusually severe cold from which she was suffering at the beginning of the treatment. The fact that no great discomfort was experienced in so confined an atmosphere must be ascribed to the absorption of the carbonic acid of the expired breath by the lime, the odor of which was very per-

ceptible in the atmosphere of the tent. The case was a very serious one, and hope was well nigh abandoned on one or two occasions; but by the timely use of turpeth mineral the liquified membrane was removed, and the threatening symptoms disappeared. After the fifth day improvement was so manifest that a gradual relaxing of the method was begun, and in a few more days it was entirely discontinued. The results of treatment could not have been more obvious and satisfactory, recovery being rapid and complete. As soon as the child was well enough to travel it was taken on a visit to friends in Washington. After three weeks absence it returned and occupied the same room. Some days later its brother, aged six, who had been sent away shortly after the beginning of its illness, but had returned, and now occupied the room with it, was attacked with a severe pharyngeal and nasal diphtheria, which lasted for several weeks.

Diphtheria and Paralysis of the Vocal Cords.

From a lecture by Dr. MORRELL MACKENZIE, published in *Med. Record*, we extract the following:

I think that, at the beginning, diphtheria is a local disease. I believe that the effect of the poison may sometimes be so great that the disease appears to be constitutional from the commencement. I believe that such cases are analogous to those of scarlet fever or small-pox, where the patient is struck down at the very moment of the invasion of the disease. The poison must enter through some part of the system, and I believe that it is local at the beginning. These points bear upon prognosis, and are of great importance. From prognosis we will now pass to

TREATMENT.

Here, again, remedies of the most varied character possible have been recommended. I recollect reading a paper written by a French physician, in which he said he bled every patient, and that he had treated fifty or sixty, and every one recovered. All I can say is that if we should treat diphtheria in London in this way, I think we would almost be prosecuted. It is exceedingly bad treatment. It only shows that it is possible to make a bad diagnosis, or else it is possible for some people to stand depletion in a most extraordinary manner.

The first great point in the treatment of this disease is to attend to constitutional measures and then to local treatment. The constitutional treatment is of no less importance than the local. It is necessary to support the patient from the beginning, and stimulants are of the utmost importance. Do not wait until the patient becomes depressed, but give stimulants from the very commencement. This is an exception to all diseases, and you must begin with stimulants at the commencement, and give them in the more solid form, such as brandy diluted with water, or port wine; such as furnish nutriment as well as alcohol. When the patient is beginning to recover, the light wines, especially champagne, are useful; but, in the early stages, port wine with water is one of the most useful you can give.

Stimulants must be given during the night as well as during the day in a very large number of cases. I have seen many cases where patients have died through want of having stimulants administered during the night. In young children it is very frequently necessary to awaken the patient and give stimulants. As a general rule, it is bad to wake a patient out of a refreshing sleep

to give medicines; but here is an exception, and I would say that if the child sleeps more than four hours, it must be awakened and stimulants and nourishment administered.

We now pass on from the use of stimulants to the use of medicines. Here, again, we meet with a very great variety, but the most useful, perhaps, of all is the perchloride of iron. In this matter I am entirely in accord with Professor Jacobi, who has found the remedy more useful than any other. Professor Jacobi has laid it down that this medicine should be given in full doses. It is also important to give a per salt of iron, which can be assimilated with comparative ease, and probably the perchloride is the best you can use, and of it at least a drachm a day, diluted with water, should be administered; fifteen drops, well diluted with water, four times a day. The only time when I have not given the perchloride of iron has been when I have been trying the local effects of some agent that has been employed. Quinine is a very useful medicine. When the temperature is high it has a very great effect in bringing it down nearly or quite to the normal. These are perhaps the most important of the constitutional remedies.

All sorts of specifics have been recommended, but I have not had much success with them. Chlorate of potash has been very much praised both as a constitutional and a local medicine. You may give it, because it cannot, in proper doses, do much harm, and it may do some good. There is one remedy which has been recommended by a gentleman whom I see before me, Dr. Beverley Robinson, and that is copaiba, which has an important effect upon mucous membranes, as possibly some of you may have had occasion to observe. But its effects are not confined to the mucous membrane of the urethra. It also pro-

duces a marked effect upon the mucous membrane of the pharynx and larynx, and that of the whole bronchial tract. I have tried Dr. Robinson's recommendation, giving the medicine in the form of pearls, which the French make, and which children take very easily, and I have administered them with great success. But I must mention that I have used it in the catharrhal form of diphtheria—the milder cases where the exudation is not very adhesive. When the more serious cases of diphtheria are about, you get a large number of cases of catarrhal diphtheria, and in those you will find great benefit following the administration of copaiba.

We will next pass to local remedies, and here again we have a very wide field. A great many doctors may go through a lifetime and see only a few cases of diphtheria. Some meet with severe epidemics, and others with epidemics mild in character. The consequence is that an immense number of remedies are not only recommended, but the doctors say that they have not lost a case since they began to use such and such remedies. You must look upon such statements with great suspicion, and it is safe to consider that the doctors who have treated so large a number of cases with such uniform success have, at least, treated a mild type of diphtheria.

The local remedies in most common vogue are lime-water and lactic acid. Both of these remedies have one great advantage; they do not do any harm. and here I may say, gentlemen, that it is a great thing, when you are trying a remedy, to use one that does no harm. In earlier days severe caustics were used, such as hydrochloric acid, nitrate of silver, and, if the patient recovered, it was always thought that event was due to the acid or the silver. But all that has been changed. We now know that

if strong caustics are used the effect is almost always to cause extension of the disease. The remedy inflames and irritates, and a false membrane is formed in close contiguity to that which previously existed. When we were suddenly told by German physicians that lactic acid was used with great benefit, and also lime-water, the news was so gratifying that we all used these remedies, which were not injurious or painful to the patient. Both have been found useful.

I ought to say here that certain solutions have been said to be useful because of the effect they produce upon the false membrane, causing it to gradually dissolve and disappear in a short time. But, unfortunately, when we have to deal with the living subject we have a totally different condition of things from that which is present in making experiments, and I have found that when using substances locally sufficient to have any effect upon the false membrane, they had an irritating effect on the mucous membrane which I was treating. Hence I returned to the use of such remedies as do not irritate, and have given up those which had a reputation for dissolving false membrane. With regard to lactic acid and lime-water, they do not have much effect upon the false membrane in the test-tube, but they certainly do seem to have considerable effect when applied to false membrane growing upon mucous membrane. It is very difficult to make accurate observations with regard to the progress of the disease from hour to hour in children; but I have had opportunity to try both remedies upon false membrane inside of the lip and upon the tongue, where I could watch the effect. I recollect three cases in which I tried the experiment with lime-water where false membrane was growing upon the inside of the lip. I treated

one side with lime-water and left the other to nature, and the side treated rapidly improved, while the other remained stationary. So I believe that lime-water is useful as a local application, and in this respect I differ with my friend Dr. Jacobi, who believes that both lactic acid and lime-water have been over-estimated. I strongly recommend that you should use them in every case.

We now pass on to another class of remedies, which I wish to bring to your notice, namely, those which shut out the air. This class of remedies I have introduced, and they have been employed in England to some extent. I refer to what may be called varnishing the mucous membrane with benzoin, or tolu dissolved in ether or chloroform or alcohol, and also used in various mixtures. I found as the result of considerable experiment that tolu dissolved in ether in the proportion of 1 to 5, made an excellent varnish, and that when applied to the mucous membrane it did not cause pain or inconvenience, was sufficiently strong to hold, and did not require to be repeated. Many of these local remedies have been recommended on the ground that they destroy germs. Just here it occurs to me that I have omitted to speak of carbolic acid and salicylic acid, etc. Carbolic acid is an excellent remedy, and it has the effect, as has been demonstrated, of destroying germs, and if used sufficiently diluted it will do no harm.

All this class of remedies have been recommended upon the scientific ground that they destroy germs.

The principle upon which I have introduced the remedies which varnish the mucous membrane is, that whatever the poisonous element may be, whether a vegetable growth or some other germ, or something else, this living matter that causes false membrane to be formed, re-

quires the presence of air. Directly you exclude the air you prevent the growth of germs which require air for their existence. As soon as possible, therefore, I apply this varnish over the false membrane; not only over the false membrane, but all around it. It is of itself to a certain extent a germ destroyer, but everything depends upon the coating of varnish being air-tight. Some of my friends, at first, found considerable difficulty in applying it, and I also had the same experience. At first I wiped the surface, to which it was to be applied, with blotting-paper. I carefully applied this absorbing material to different parts of the throat, and then immediately afterwards applied this varnish. This plan answers perfectly well when you can do it; but every now and then you will find a patient who will retch a little just after the blotting-paper has touched the surface, and the mucous membrane becomes wet before you can apply the varnish. I then adopted the plan of putting a piece of lint around my finger and drying the throat with this, and then quickly applying the varnish with a brush. This does not hurt the child, and I speak of children because nine-tenths of our cases occur among children, and it answers perfectly well; but if you should have difficulty with this, I should advise you to apply the varnish all the same. I have had several patients treated entirely by the use of the varnish, without constitutional remedies, and with good results.

I shall feel exceedingly proud if, as the result of this lecture, gentlemen shall try the effect of this varnish.

I will now say a few words with reference to the use of steam and the use of ice. Both these remedies are useful, but they should be applied in different classes of cases. In the early stages it is very useful to

employ ice. It affords the greatest comfort to the patient. Let them have ice, and take as much as possible. Many young children are pleased to have pieces of ice put into their mouths. There is no doubt that it restricts the associated inflammation so often present. In the early stages it is most desirable to use ice, and you can use any amount of it without doing harm. It is only in exceptional cases, where the patient is very much depressed, and in the very advanced degrees of poisoning, where there is gangrene, that ice does harm. In many cases it diminishes the violence of the attack.

With reference to steam, it was first recommended, I think, by Mr. Prosser James, of London. Afterward it was pointed out by Oertel that steam must cure almost every case, and that it was the only remedy of any value at all, because the effect is to separate the false membrane from the mucous membrane. The fact is that when a certain point in the disease has been reached, when the false membrane is beginning to separate, steam is useful. At that time its effect is admirable. In the early stages I do not think it does any good. I think it lowers the vitality of the tissues, and that its effect is most prejudicial; but when the false membrane shows evidences of separating from the mucous membrane its effect is most beneficial. So you need have no fear of clashing heat and cold, for you use ice at first and steam afterward, when the disease has reached a certain stage. One great advantage of steam is that you can use some antiseptic with it, such as carbolic acid, salicylic acid, or any other substance you may choose. And I should advise you to use some mild antiseptic at this stage of the disease, because a certain amount of gangrene is usually present.

TRACHEOTOMY.

These, gentlemen, are the important points which I have to bring before you, and in closing I will make a few remarks only with regard to tracheotomy. The question often arises whether or not you will perform tracheotomy. I may say here that my friend J. Solis Cohen, of Philadelphia, who is with us to-day, has published one of the most complete essays on tracheotomy ever published in the English language. I think the conclusion which may be drawn from his paper is that the operation should be performed at a comparatively early stage. That is the conviction which I have. My advice is that when once there is considerable false membrane in the larynx, when inspiration is so difficult that you see falling in of the sternum each time the patient breathes, and each supraclavicular space deepened with every inspiration, the time has arrived for tracheotomy. But you will examine the whole of the patient's thorax, and most carefully the posterior part of the chest, to see if air enters both lungs. If you find one lung seriously obstructed, I myself should advise against tracheotomy. If you find that air does not enter the lung beyond the bifurcation of the bronchus, tracheotomy will be useless. Still there are cases in which we have everything to hope if a cure can be effected. But at the same time we should consider the interests of surgery, and when I say the interests of surgery I mean the interests of the entire public, as well as those of the surgeon. If we perform the operation in a case almost entirely hopeless, we have to consider the effect produced upon the feelings of friends when a similar operation is to be performed in a similar case. The point which I wish to insist upon is, that if you perform tracheotomy you should

do it directly it becomes necessary. You must not wait until the case becomes hopeless. If you do this, you will find that a large number of cases which appear hopeless will terminate in recovery. On the other hand, if you perform tracheotomy too early, you will perform it in a large number of cases which will recover without it. I think the very favorable statistics with regard to the operation, especially those furnished us from Parisian hospitals, are partly the result of the operation being performed where it should not have been performed; that is, in cases of catarrhal laryngitis, slight cases of diphtheria. In this manner you can get the most favorable statistics, but it is not a fair procedure to perform tracheotomy before there are distinct signs of laryngeal dyspnoea.

Now, gentlemen, if you observe the directions which I have recommended, I do not think you will cure all cases of diphtheria, but I think you will meet with a certain amount of success, and I also think that you will be able to rescue many patients from imminent death.

DISEASES OF THE NERVOUS SYSTEM.

Speck on the Relation of Mental Activity to Tissue Metamorphosis.

Dr. SPECK (*Archiv für Pathol. and Pharm.*, Band xv.) after numerous and careful experiments on himself and others, concludes that mental work does not to any perceptible degree affect the metamorphosis of the tissues of the body. The total quantity of the urine is not altered, nor are the urea, uric acid, chlorides or sulphates increased or diminished. Contrary to expectation, there is not the slightest increase in the excreted phosphates. The proportion also of oxygen, nitrogen, and carbonic acid in the respired air is much the same as

when the brain is not actively engaged. The molecular changes which occur in the brain during its activity are, therefore, either not oxidation processes, or, if so, are so little in amount as to escape detection by the methods of investigation employed.—*London Med. Record.*

Sick Headache.

Surgeon Major ROEHRING, of Amberg, reports in No. 32 of the *Allg. Med. Centr. Zeit.*, April 22, 1882, a case of headache of long standing, which he cured by salicylate of sodium, which confirms the observation of Dr. Oehlschlager, of Danzig, who first contended that we possessed in salicylic acid one of the most reliable remedies for neuralgia. This cannot astonish us if we remember that the action of salicylic acid is, in more than one respect, and especially in its influence on the nervous centres, analogous to quinine.

While out with the troops on manœuvre, Dr. Roehring was called to visit the sixteen year old son of a poor peasant family, in a neighboring village. The boy who had shown himself very diligent at school, had been suffering from his sixth year several days every week, from the most intense headache, which had not been relieved by any of the many remedies tried for this purpose. A careful examination did not reveal any organic lesion or any cause for the pain, which seemed to be neuralgic in character, a purely nervous headache. Roehring had just been reading the observations of Oehlschlager, and knowing from the names of the physicians who had been already attending the poor boy, that all the common remedies for neuralgia had been given a fair trial, thought this a good opportunity to test the virtue of salicylate of sodium. He gave the boy, who, in consequence of the severity of the pain, was not able to leave his bed, ten grains

of the remedy every three hours, and was surprised to see the patient the next day in his tent and with smiling face. The boy admitted that he for years had not been feeling so well as he did then. The remedy was continued, but in less frequent doses, for a few days longer; the headache did not return. Several months later Dr. Roehring wrote to the school teacher of the boy, and was informed that the latter had, during all this time, been totally free of his former pain, that he was much brighter than formerly, and evidently enjoying the best of health.

It may be worth while to give the remedy a more extensive trial, and the more so, as we are only too often at a loss what to do in stubborn cases of so-called nervous headache.—*Medical and Surgical Journal*.

In Nervous Debility.

R. Zinci phosphat., grs. 20-40; acidi phosphor. dil., $3\frac{1}{2}$; tr. cinchon. flav., 36; aquæ menth. pip. ad. 38.

M. Sig. One-sixth part three times a day.

The Hypnotic Value of Cannabin Tannicum.

The tannate of cannabin is a yellowish-brown powder, insoluble in water, or ether, slightly soluble in alcohol, and easily dissolved in water that has been made slightly alkaline. In the distillation of hemp, two volatile oils are developed, cannabin oil and its hydrate. These are rapidly acting irritant poisons. They are said to be removed in the preparation of the tannate. In describing the dosage and practical use of the cannabin, Dr. FRONMÜLLER states (*Medical Record*) that he has used hemp itself considerably for thirty years, and that there has been a steady increase in the strength of the preparations furnish-

ed him. Thus thirty years ago he began with a dose of eight grains; ten years later he had to reduce it to four, and latterly to two grains. The dose of the present preparation, the tannate, ranges between two grains and ten grains, the most frequent dose being five grains. The drug was used fifty-seven times in hospital and six times in private practice. The patients consisted of twenty-one men and forty-two women, varying in age for the most part between twenty and forty years. Forty of them were suffering from phthisis. The remainder had different diseases, generally of a chronic nature. The common symptoms in all cases was insomnia, and it was for its hypnotic effect that the cannabin was given. Good results were obtained in thirty-seven cases out of sixty-three, and moderately good results in fifteen cases. It was called a good result when quiet and uninterrupted sleep came on within an hour after taking the medicine, the patient awakening with no toxic after-effect. In twelve cases no result was produced. Many of the patients had been taking opium. From the sixty-three trials thus reported, Dr. Fronmüller concludes that cannabin tannicum is a very useful hypnotic, powerful without being dangerous, and one which does not disturb the secretions or leave unpleasant toxic after-effects if given in proper doses. It is very probable that some of our American fluid extracts now in the market will secure about the same results as those obtained by Merck's preparation.—*Chic. Med. Review*.

Neuralgia.

From a clinical lecture by Dr. WILLIAM PEPPER, reported in the *Medical Gazette*, we gather the following: Neuralgia, like diarrhoea and dropsy, is a symptom of general or special disorder

rather than a disease proper. Its cause may be various. It may be due to local disease of the neurilemma, to irregular menstruation, to impaired general health, to extremes of heat and cold, to pressure, &c. It also frequently occurs in recovery from arsenical poisoning. For convenience, neuralgia may be divided into two classes. In the first class the paroxysms of pain come on regularly, but at distant intervals. These forms are mostly symptomatic of several varieties of cachexia. First, there is the malarial form. This can generally be distinguished by the history of the case and the periodicity of the paroxysms, also by its yielding readily to large doses of quinine. Second, migraine, so-called hemicrania. It is usually connected with disturbed menstruation or is hereditary in its nature. Hereditary megrim usually attacks the first branch of the fifth pair of nerves. The pain which centers in the eye or in the supra-orbital or temporal fossa is very acute. There is nearly always nausea or vomiting. The third variety is the anæmic, chlorotic, or syphilitic, and is due to an impoverished diseased state of the blood. The cause of this neuralgia is quite frequently over-exertion. Fourth, rheumatic neuritis or face-ache is to be distinguished from periostitis by the locality of the pain. The existence of rheumatic pains in other parts of the body will usually strengthen the diagnosis. The fifth variety is due to toxic causes, such as lead or arsenic poisoning. The blue line on the gums or the characteristic signs of arsenical poison will easily separate this form from the others. Under the second great group of neuralgiæ are those coming on in short paroxysms at short intervals, and generally as reflex inductions of peripheral irritation or centric pressure. We find two separate forms: tic douloureux, anæsthesia dolorosa. These

forms usually go by the name of trigeminal neuralgias. The trigeminal is a nerve of both sensation and motion. Therefore either or both of its functions may be affected. Its passage through bony canals make it especially liable to pressure. The three special points of pain are the supra-orbital, the infra-orbital, and the mental foramina. In tic douloureux there is both pain and spasm. The causes of this form of neuralgia are usually peripheral in their origin, as a decayed tooth or the pressure of a cicatrix upon one of the superficial nerve branches, or local inflammation of the neurilemma. In some cases the lesion may be centric. The pain is excruciating. The late Dr. Pemberton, of England, is said to have stamped the bottom out of his carriage during one of these paroxysms of pain.

DIGESTIVE TRACT.

On the Treatment of Chronic Dysentery by Voluminous Enemata of Nitrate of Silver.

STEPHEN MACKENZIE, M. D., F.R.C.P. (*Lancet*):

In the treatment of ulceration of mucous membranes within reach of sight and touch, all practical physicians and surgeons are convinced of the great importance of local applications, whether the seat of the disease be the pharynx, the larynx, the eye, the cervix uteri, or elsewhere. In these situations, whether the ulceration be of constitutional or local origin, we employ local treatment, with or without internal medication, and as the effects of treatment can be observed, no one doubts its efficacy. All practical surgeons are assured of the beneficial influence of applications of nitrate of silver and other mineral astringents and mild escharotics in treating inflammations of mucous membranes.

How different is the treatment of dysentery from that of inflammation of the upper part of the alimentary tract. It may, of course, be remarked that treatment which is obviously beneficial to such parts as our hands can reach cannot, on account of physical difficulties, be applied to the length of the colon. But this difficulty is not wholly real. With a view of rendering our practice in the treatment of dysentery more successful, and more in accordance with our procedures elsewhere, Dr. Horatio Wood, of Philadelphia, has suggested the use of a large enemata of nitrate of silver, so as to bathe with a solution of this salt the whole mucous membrane of the colon. This treatment he has appropriately designated "the rational treatment of dysentery." I am aware that enemata have long been employed in the treatment of dysentery, but the importance of *large* enemata has not been insisted on, and their use is not general. Ringer, Gairdner, Bristowe, Niemeyer and others recommend the employment of enemata, and, in some instances, of nitrate of silver, but none enjoin the use of such large enemata of nitrate of silver as recommended by Dr. Horatio Wood.

"The disuse of local applications in dysentery is largely, no doubt," Dr. Wood observes, "the result of our former inability to make use of applications to any other than the extreme lower portions of the colon. By the use of forced enemata, so called, we are now, however, able to reach every part of the large intestine. In giving such injections, it should be first remembered that the name is a misnomer; that no force should ever be used. The patient should be brought to the edge of a hard bed, placed in a position somewhat resembling that for lithotomy, his buttocks resting upon a hard pillow in such a

way as to elevate the pelvis, and cause the injected fluid naturally to flow downward and inward. A well-oiled, smooth, somewhat flexible, hard tube, with openings at the side (an œsophageal tube will answer well,) and a closed end, must then gently and slowly be introduced from eight to twelve inches into the rectum. The free outer end of this may be connected with a Davidson's syringe, and the fluid thus be slowly pumped in. A better plan is to unite it with a flexible India-rubber tube, in the end of which a funnel is inserted. This being elevated five or six feet, the water is poured in, and by its own weight, with irresistible gentleness, forces its way into the gut. Instead of a funnel being used, the tube may be so arranged as to empty a bucket or other reservoir of water, placed five or six feet above the patient. A direct connection may be made, or the principle of the syphon taken advantage of. Finally, the so-called fountain syringe may be substituted. In any case the liquid should be about the temperature of the body, so as not to provoke peristalsis by the stimulus of heat or cold."

Dr. Wood writes that, whilst some considerations would lead us to expect variety in the character and strength of the applications that would be likely to be serviceable, his experience of throat affections led him to select nitrate of silver in the first instance, and he has been so satisfied with its results that he has employed no other. Drachm doses have, in his hands, never occasioned constitutional symptoms, and less than forty-grain doses have not accomplished much good. In one of my own cases, to be narrated, a single enema of thirty grains of nitrate of silver in three pints of water caused the complete cessation of chronic dysentery that had lasted two years. This I regard as exceptional. I

believe that, as a rule, at least a drachm of nitrate of silver to three pints of water should be used, and I have employed as much as a drachm and a half of nitrate of silver to this quantity of water with good results and without danger. Dr. Wood properly discusses the possible effects of the application for a longer period than occurs elsewhere of so large a dose of nitrate of silver to an absorbent surface, but has never seen the least inconvenience arising from it. My experience is in entire accord with it. He suggested that, in case of the enema being retained, and fear arising as to the toxic effects of a large dose, a solution of common salt should be at hand to inject and neutralize the nitrate of silver. In two cases in my absence, my house-physician thought it desirable to do so.

I, myself, have been led to try perchloride of iron instead of nitrate of silver, as the former would be wholly destitute of the dangers entailed by the use of the latter, and any absorption which took place would be an advantage rather than the reverse. But my results have not been nearly so good with iron as with silver. I have not experienced any practical difficulty, inconvenience, or the least danger with these large and comparatively strong injections of nitrate of silver, whilst the results have been so encouraging that I am anxious the treatment should be tried on a larger scale, and by other observers.

It will, of course, be understood that this plan of treatment is not suitable for diseases of the intestines above the ileo-cæcal valve.—*South. Med. Record.*

Oleoresin of Male Fern: Increasing its Efficacy against Tape Worm.

According to E. DIETERICH, the frequent failure of oleoresin of male fern as a remedy against tapeworm is to be

ascribed to its irrational administration. It has become known that the popular "worm doctors," who use almost exclusively the oleoresin of male fern, and who hardly ever meet with a failure, administer the remedy in conjunction with castor oil, instead of following it by the oil after one or two hours, as is usually done by practitioners. The object is to bring the extract, in an unaltered or undigested condition, in contact with the worm. The experiments which have been made by mixing one part of the oleoresin with two parts of castor oil have been very successful, and this mode of administration deserves therefore the preference. Oleoresin of male fern is apt to derange the stomach, and when enveloped partly in the oil is likely to pass it more rapidly, which constitutes another advantage. The mixture has, it is true, an unpleasant taste. This may, however, be disguised by filling it in capsules of about three grams (forty-five grains) each. The dose may be regulated from six capsules (equal to six grams or ninety grains of the oleoresin and twelve grams of castor oil) to seven or eight more, according to circumstances. It is advisable to empty the bowels on the preceding day by a mild purgative, best by castor oil. — *New Remedies.*

The Treatment of Intussusception.]

In the September number of the *New York Medical Journal and Obstetrical Review*, Dr. W. R. GILLETTE, Physician to Bellevue Hospital, relates a case of intussusception in a child nine months old, relieved by injections of water, the administration of chloroform by inhalation, and manipulation of the tumor felt through the abdominal wall. This, he states, is the third case of intussusception in infants which he has seen, and which he has been able to reduce by

these means. He thinks that these cases, from the philosophy of their condition, and the necessary measures for relief, are best managed in the way indicated. In two other instances, in which he saw and advised this treatment, reduction was utterly impossible under the other methods tried. The children in each of these cases were held while struggling, and the injections forced into them against all voluntary and involuntary efforts which they could make. He deems the administration of chloroform almost absolutely necessary in these cases. The reason is not difficult to find, inasmuch as, while it gives us such perfect control of the patient, it also eliminates the element of muscular spasm. Moreover, massage is a powerful adjuvant to the hydrostatic pressure of water in these cases. In the first two cases, the obstruction was not overcome until massage also was employed.—*Medical Record*.

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DISEASES OF THE URINARY ORGANS.

Treatment of Diabetes by Bromide of Potassium.

Before the meeting of the Académie de Médecine a member read a paper on the treatment of diabetes by bromide of potassium. For the last six years the author has made this disease the object of his researches, and during that period he treated fifteen cases. He ignored entirely the classic *régime* of gluten bread, etc., being of the opinion that the disease consisted, not in the presence of sugar in the urine, but in the disorder of the organism, which produced the sugar in excess. Having had a patient who was diabetic, but who consulted him for certain nervous affections, he observed that under the influence of the bromide of potassium, of which he prescribed a drachm a day,

the former disease yielded. This case gave him the idea to make experiments on rabbits, in which he produced artificially diabetes in touching the floor of the fourth ventricle, according to the method of Claude Bernard. Four grains of the drug injected into the veins caused the sugar to disappear in each case. Consequently, ever since, the author has entirely adopted this drug in the treatment of the disease in question, and always with good results. The author further insisted on the necessity of employing muscular exercise of every kind. The use of alkalies, and of iron, arsenic, quinine, according to their several indications, form part of the general treatment. There is one point worthy of remark in the above communication, and that is, the complete disregard as to *régime*, which must be beneficial to the patient in that he is relieved from the irksomeness of observing a certain imposed diet, which soon disgusts him, and what is more grave, keeps him continually dwelling on the affection from which he suffers, a fact which often leads to another malady, which, though less formidable, is not without producing a deleterious effect on the constitution, already weakened by the primitive disease, hypochondria. If further researches verify the efficacy of the observations of the learned author, the treatment of this grave affection will have made a *pas en avant*.—*Ibid*.

Fuchsine in Bright's Disease.

The *Canada Medical and Surgical Journal* says that this remedy has been used extensively by Dr. Renzi, of Geneva, given in pill form, .025 gram ($\frac{5}{16}$ grain) twice a day. There was at once a noted diminution of the albumen and dropsy. The urine was colored for some days. No result followed in one case. Similar experience was had

by Brochut, of Paris. In every case albumen disappeared rapidly and entirely, the treatment generally lasting from four to six months. Dr. James Sawyer has used it mostly in cases of contracted kidney, with good results and no untoward physiological effect. It colors the mucous membranes of the digestive organs a deep red, and also the plasma of the blood, due to its presence, not to blood change.

—o— DISEASES OF THE RESPIRATORY ORGANS.

Experiments in the Physiology and Pathology of Mucous Membranes.

In a series of articles recently published, Prof M. J. ROSEBACH, of Würzburg, has contributed some original facts to the subject of the physiology and pathology of mucous membranes. His researches point, also, to certain new therapeutical methods in treating diseases of these tissues (*Medical Record*). Experiments were made to discover the effect of various drugs and reagents upon the tracheal mucous membrane. A hot bread poultice was applied, then withdrawn and an ice bag substituted. The membrane at once became whitened and bloodless. In one or two minutes this pale appearance changed to blue, showing venous stasis, and at this time a copious secretion was poured out. Upon repeating the applications of hot and cold, the same phenomena were observed, but they came on more slowly and were less marked. Professor Rossbach's experimental studies with various drugs used in treating pulmonary or bronchial disease, lead to some conclusions that quite contradict ordinary views, if not ordinary experience. As regards the alkalies (carbonate of soda, chloride of ammonium, etc.), for example, Rossbach claims that they

do not increase mucous secretion, but the reverse. He experimented by injecting these salts directly into the blood, then watching the mucous membrane. After such injections the mucous was secreted more slowly and in less amount. The favorable action of alkalies in bronchial disease is attributed to a diminution of congestion and lessened secretion which they produce. Rossbach could observe no effect from the direct application of alkalies, as in inhalation. The direct pencilling of the membrane with astringent solutions, such as alum, tannin, nitrate of silver in four per cent. solution, caused diminution of secretion and a clouding of the epithelium. Experiments with oil of turpentine gave some interesting results. If air which had passed through turpentine was blown upon the mucous membrane the secretion was diminished or stopped. Direct application of turpentine in watery solution, however, caused an increased secretion with diminished amount of blood-supply. This substance is a most valuable one, therefore, says Rossbach, since it is at the same time an antiphlogistic and expectorant. The chief direct stimulants of the mucous secretion were found to be apomorphine, emetin (from ipecac), and pilocarpin. Of these apomorphine is practically the best and most useful. Of agents which lessen the secretion atropin was found to be most powerful, being able to check the function entirely. Morphine, on the other hand, reduced by about one-fifth the normal amount. As a practical outcome of his experiments Rossbach cites a number of cases in which he has used the drugs above mentioned. In his opinion apomorphine is one of the best expedients. Combinations of it with morphine are also effective.—*Chic. Med. Review*.

Acute Phthisis Cured.

J. FERGUSON, B. A., M. B., L. R. C. P., reports in the *Canadian Journal of Medical Sciences* a case in which all the signs, general and local, of this disease, were well marked, the patient at the time when treatment was begun presenting those symptoms usually considered as characteristic of the last stage of the disease. She rallied under the following treatment, however, and is now apparently well :

A small pasteboard cone to fit over the mouth was made, holding a little cotton wool. On the cotton wool was put daily a few drops of the following : Acid carbol., \mathfrak{z} ii ; tinct. iodi. etherealis, \mathfrak{z} ii ; creasoti, \mathfrak{z} i ; vini. rect., \mathfrak{z} i. The cone carrying this was kept on the mouth almost constantly. For the dyspnea I tried nitro-glycerin, but without any benefit, and then gave ammon. carb., gr. v. ; tinct. card. co. m. xv. ; spts. chloroform, m. xv. ; aquæ \mathfrak{z} ss., as often as required. After a short time this mixture was given regularly every four hours. The pain in the feet and legs was treated by applying belladonna and aconite ointments in equal parts freely and bandaging them evenly. In about three weeks the pain had almost disappeared. The vomiting yielded to nothing but injections of morphia and fly-blisters over the stomach. For diarrhœa, a half grain of cupri. sulph. was tried, but found too much for the weakened stomach to bear, so that it was ordered in one-eighth of a grain, with one-twentieth of a grain of morphia in the form of pills, taken about every hour. Fl. ext. coto bark, belladonna, and zinc sulphate were tried for the sweating, but with doubtful efficacy. Ergotin, however, gave much better results, and caused no constitutional disturbance of any kind. The

throat was sprayed with the following : Acid. hydrocyan. \mathfrak{z} ii. ; acid lactici, \mathfrak{z} ii. ; morphia sulph. gr. iv. ; glycerin, \mathfrak{z} i. ; aquæ ad., \mathfrak{z} iv. Under this the sores in the throat speedily healed, the voice began to return, and a glassful of milk could be taken at one drink. The ulcerated condition of the throat has not returned. Believing in the beneficial action of arsenic in tubercular diseases, the patient was ordered one minim of liq. sodæ arsenitis every half hour, or hour, in milk. Owing to the great irritability of the stomach, a larger dose could not be borne. Best whisky was pushed as far as it could be, keeping inside the limits of any constitutional disturbance. In this way from six to ten ounces per day were consumed. Up to the beginning of April no preparation of cod liver oil could be taken, but since that date hydroleine has been used.

Such is, briefly, the treatment adopted in a well marked case of phthisis with the usual conditions of coughing, sweating, diarrhœa, &c. The patient now sleeps well, has no diarrhœa, appetite good, and takes solids ; pain in feet and legs gone ; gaining weight rapidly ; night-sweating a rare occurrence and slight ; vomiting entirely ceased ; no soreness in the throat and voice strong. The pulse is 80, temperature normal, and respirations 21. She intends going away soon to spend the summer in the country. The diet was mainly milk.

When the hopeless condition of the patient is considered and her present condition of improvement, I am inclined to think that the acute form of tubercular phthisis is not necessarily fatal, and that much can be done by persistent efforts in treating, on sound scientific grounds, the various symptoms as they arise in each case. It has been shown, especially in Germany, that ar-

senic is really a remedial agent in this disease, while the local treatment by inhalations and sprays has been too much neglected. There is, perhaps, much truth in the theory that acute tubercular disease is really one of the continued fevers with a definite lesion in the form of tubercles, as typhoid with its intestinal ulcers. Should such really prove to be the case, then we may hope for a fairly successful treatment, and the great object is to keep up the patient till the disease has run its course. There are three great laws that we may look upon now as fully settled: 1. That tubercular formation may cease either with or without treatment, and no further progress be made by the disease; 2. That tubercles once formed may undergo absorption, just as other inflammatory products do on many occasions; 3. That if the formation of tubercles cease, and those already deposited capable of absorption, then recovery is possible. It is therefore of the utmost moment to make this arrest in the disease, and to favor the removal of existing deposits.

Bizzozero on the Diagnostic Signification of the Alveolar Epithelium of the Lung in Sputum.

The large granular epithelium that appears in sputum the writer considers undoubtedly proceeds from the alveoli. He recalls the fact that in the alveoli there are two distinct kinds of epithelium, viz.: broad, squamal, and smaller, but thicker, and more granular cells. It is the latter class which undergoes rapid proliferation in inflammation, the other remaining unaltered. And it is the latter class that appears in the sputum. When present in large quantity in abundant sputum they form a bad symptom, as indicating a general catarrh of the alveoli; but if in small quantity, they have no significance.—*London Medical Record*.

Coto in Night-Sweats of Phthisis.

Dr. J. STEWART (*Canada Lancet*) has administered ten minim doses of the fluid extract of coto every night to twenty-two cases of night-sweats from phthisis, with the following results: In sixteen cases the arrest of the night-sweats was long continued. In four cases the arrest was very temporary in character. In two cases the remedy had no effect. The astringent properties of the drug are probably what give it value in this complication of phthisis, and these results of Dr. Stewart should certainly lead to its further trial in such conditions.—*Chicago Med. Review*.

Hydrastin in Laryngeal Phthisis.

Dr. BIRD (*Australian Medical Journal*) claims good results from the treatment of laryngeal phthisis with a spray composed of hydrastin, glycerine, borax and morphia. A combination of this kind would seem likely to be of advantage.—*Ibid*.

Treatment of Œdema of the Glottis by Pilocarpine.

M. SOREL, who is a military surgeon at Setif, Algeria, sent to the Societe de Therapeutique, in Paris (*Jour. de Méd. de Paris*), a case of œdema of the glottis consecutive on typhoid fever, and cured by pilocarpine. A previous application of fifteen leeches had not given any relief. Ipecacuanha had no effect whatever, and subcutaneous injections of morphia had only given temporary relief. Almost in despair, M. Sorel tried an injection of a centigramme of nitrate of pilocarpine. A slight perspiration appeared, and the troublesome symptoms were removed. On the same evening a fresh injection of a centigramme was made, and on the next day two centigrammes. The patient soon recovered his strength, and became convalescent.

MEDICINE.

CONSTITUTIONAL DISEASES.

On the Bacteria of Typhoid Fever.

The *Medical Times and Gazette* says that Dr. Ernest Almquist, of Stockholm, who had been assiduously occupied for eight months in proving the presence of a bacterium (microbe) in the living blood in typhoid fever, records in the *Nordiskt Medicinskt Arkiv*, 1882, the conclusions at which he, so far, has arrived. He made these researches on a considerable number of preparations of normal and pathological blood, before coagulation. After coagulation, formations are found in the blood, which are perfectly similar to bacteria, and are probably formed from torn meshes of fibrine. In the blood of persons suffering from typhoid fever, bacteria are frequently found, but very small and very few. Each bacterium has the appearance of a cylindrical, short and slender rod, the extremities refracting light more powerfully than the middle, which appears more transparent. Still more rarely there are found in typhoid fever other formations—as short protoplasmatic threads, or as ovoid grains. On rare occasions he has detected the presence of an enormous mass of bacteria; but only for one or two days, in the whole course of the fever. It is not certain that a greater number will be found in severe than in abortive cases, for in these latter Dr. Almquist has often discovered a considerable number. The bacteria are found most frequently in the second and third weeks. He thinks it necessary to search for pathogenic bacteria at the bedside of the patient, and then they are found in the blood in

the purest possible condition. To obtain certain results, pure seeds must be obtained if it is wished to cultivate them or to inoculate an animal with them. Workers have, he says, too much neglected researches of this kind, and they have sought for the bacteria of a patient in the excretions, in the dead body, and even in the earth itself. In the case of typhoid fever much time and trouble are necessary, in order to find a number of bacteria sufficient to cultivate them so as to make them serve for inoculation; but it is worth the trouble, for the harvest, once found, soon gives results. In many infectious diseases it will be undoubtedly very easy to procure them, and perhaps it will be possible to fix the very day when the bacteria will be most frequently found in these cases. It may be presumed that the pathogenic bacteria can be perfectly cultivated in normal blood, especially in that of a person who has never been attacked by the fever. Dr. Almquist has cultivated this bacterium, taken on the eleventh day from the blood of one of the cases described, in a drop enclosed between two glasses, one of which was concave. From this drop there were prepared successively a series of generations, and from the second generation he succeeded in inoculating a dog, with good results. The animal was hardly ill, but on the fifteenth day he found the Peyer's patches much swollen, and containing characteristic bacteria. Without having yet finished his researches, Dr. Almquist thinks that he is able to form the following opinions, viz.: The bacterium (*microbe*) or typhoid fever is found in

the blood only by accident; it vegetates principally in the walls of the intestine, and only in very small numbers in ordinary cases, and, if more are found, he thinks they are thrombi of bacteria, which, having been detached from their places, circulate in the blood, broken into particles. He then describes six forms of bacteria, which are illustrated by microscopical drawings. He thinks, from his researches, that the microbe he describes cannot strictly be classed among the genera *Bacillus*, *Micrococcus*, or *Bacterium*, but that the series of developments comprises the following phases, viz.: The spore shoots forth a thread; several threads form a network, a mycelium, or a zooglœa of threads. If the spores are completely formed in the threads, then the zooglœa of threads may be transformed into a zooglœa of delicate grains. Dr. Almquist has not yet concluded his researches, to which he intends shortly to return.—*Med. & Surg. Reporter*.

Cardiac Symptoms in the Typhoid Fever of Children.

The epidemic of typhoid fever which has swept over Paris did not spare children, and my beds have been crowded with cases. These cases verified, in general, the well-known benignity of this disease in subjects from six to fourteen years of age. I have observed among them cardiac accidents sufficiently often to especially interest me in their study and treatment. These manifestations have been studied by Wunderlich, Hayem, Zenker, Dieulafoy and Huchard. Their clinical expressions are numerous, from syncope—leading rapidly to death, or appearing in successive attacks—exceptionally followed by recovery, to the curious phenomenon of collapse, characterized by coldness of extremities, smallness of the pulse,

cyanosis of the face, and lowering of the central temperature in a great degree. These are the two forms of functional heart trouble the most frequently observed. Rarely appearing in the first septenary, they occur most in the third week, or later, even during convalescence, when they are connected with fatty or hyaloid degeneration of the cardiac muscles. This degeneration is extensive enough in some cases to lead to a fatal result, and so slight in others as to be followed by perfect repair. This theory of the accidents I mention is the one at present generally accepted. The phenomena of collapse are the most interesting to study. They do not occur before the third and often not till the end of the third week. They are accompanied by no appreciable functional trouble. The first symptom striking the attention is the coldness of the extremities, which are sometimes cyanosed, and the smallness of the pulse pointing to the heart. The central temperature is sometimes lowered and sometimes increased considerably.

An examination of the precordial region shows feebleness of the impulse, and of the sounds, especially the first. The systolic murmur is attributed by some to an endocarditis—an opinion corroborated by an autopsy by Wunderlich—others, more numerous, attribute it to a functional trouble of the degenerated papillary muscles. This last opinion seems most probable, as this apex murmur is only temporary, persisting a greater or less time, then it disappears, or rather relocates at the base of the heart as an anemic murmur. The symptoms may be transitory or prolonged, lasting nearly a week. We had a case which had reached the end of the third week at its home, and was brought here, because of an anasarous

condition which had developed in two days. There was slight cyanosis of the lips, marked oppression, sub-crepitant rales in both lungs, a feebly-beating heart, enormously increased spleen, enlarged liver, nearly normal temperature, and no albumen in the urine. Recovery took place rapidly under treatment, as follows: Absolute quiet in bed in the horizontal position, the slightest effort carefully avoided. The most useful medicine is the subcutaneous injection of ether. This being rapidly eliminated, comparatively large doses may be given three times in twenty-four hours. Ergot is a good addition to the treatment.—*Clinic Hospital Trousseau.—Obstetric Gazette.*

Salicylic Acid in Typhoid Fever.

M. VULPIAN, according to the *British Medical Record*, has had great success with the internal use of salicylic acid in typhoid fever. He gives as much as a drachm and a half a day, in doses of four to five grains every half hour. He does not claim that it shortens the duration or lessens the mortality of the disease, but that it reduces the temperature. Of all patients treated, those who were given the acid improved most rapidly. By interrupting the treatment, M. Vulpian ascertained that the salicylic acid was really the cause of the lowering of temperature.—*Med. and Surg. Reporter.*

Sudamina in Typhoid.

M. ALBERT ROBIN has found, according to the *Lancet*, that the liquid of typhoid sudamina contains a number of fine globules of fat and some epidermic cells. It contained neither albumen nor sugar, and was not rendered opaque by the addition of alcohol. No uric acid could be discovered in it by the murexide test. An analysis showed that it

contained a considerable quantity of chlorides, but no trace of sulphates or phosphates; the proportion of water was 982, of solid matter 18, per 1,000; the solids consisting of 14 parts of organic and 4 of inorganic substances. Hence the amount of organic material eliminated by the perspiration in typhoid must be regarded as considerable.—*Ibid.*

Complication of Typhoid Fever.

M. SIREDEY has lately observed a complication of typhoid fever, not alluded to in the books in general use. It is periostitis, generally of the tibia, appearing during convalescence.—*St. Louis Medical and Surgical Journal.*

Milk as a Vehicle for Fever.

An outbreak of fever in the outskirts of Glasgow has been traced by the officers of health to a poisoned milk supply (*British Medical Journal*): "It appears that this farm when visited was found to be in a very unsanitary condition, and in the farm house itself one of the inmates had recently been suffering illness of a febrile character." By the way, what is the condition, hygienic or otherwise, of the sources from which our city milk comes? Has any one tried to find out?—*Med. Times.*

Typhoid Fever Contagion.

TIZZONI (*Annali Universali di Medicina e Chirurgia*) has recently studied typhoid fever communication, and, after an extended series of experiments, concludes: First. The insoluble organic matter obtained from potable water by simple filtration during a typhoid epidemic may produce the principal clinical and anatomical phenomena of typhoid fever if injected in distilled water beneath the skin of animals. Second.

The anatomical lesions of this experimental typhoid are produced by the presence of micrococci. Third. In some cases slight symptoms only are obtained. Fourth. Typhoid infection may be transmitted from animal to animal by injection of blood. Fifth. Typhoid virus has an elective action on the intestinal tube, even when injected hypodermically. Sixth. The soluble or insoluble substances found in the air do not produce typhoid fever when injected subcutaneously. Seventh. Typhoid phenomena are absent when the injection produces local supuration. Eighth. The infecting substances lose their infectives when kept two months in a close vase, and when the micrococci in them are no longer active.—*Gaillard's Medical Journal*.

A Valuable Mixture for Chills.

A subscriber sends us the following as a valuable mixture for chills, and desires to give it more extended notice, he being able to heartily recommend it: \mathcal{R} . Quinine sulph., cinchonidia sulph., grs. xxx; acid sulph. m. x.; liq. potass. arsen., f 3 i; extract nucis. vom. fl., m. x.; aquæ q. s. ad., f 3 iv. Mix. Tablespoonful every four hours, when fever is off.—*Pharmacist and Chemist*.

Sulphur and Malaria.

At a recent meeting of the Paris Academy, M. d'Abbadie called attention to some facts regarding marsh fever. Some African elephant-hunters from plateaus with comparatively cool climate brave the hottest and most deleterious Ethiopian regions with impunity, which they attribute to their habit of daily fumigation of the naked body with sulphur. It is interesting to know whether sulphurous emanations, received involuntarily, have a like effect. From inquiries

made by M. Fouque, it appears that in Sicily, while most of the sulphur mines are in high districts and free from malaria, a few are at a low level, where intermittent fever prevails. In the latter districts, while the population of the neighboring villages is attacked by fever in the proportion of ninety per cent., the workmen in the sulphur mines suffer much less, not more than eight or nine per cent. being attacked. Some other facts, tending to show the anti-malarial influence of sulphur, are given—*Med. Review*.

Chronic Chills.

We have found the following to be a very reliable remedy in chronic chills: \mathcal{R} . Sulph. cinchonidia; chenoidin, aa grs. 60; podophyllin, grs. iii.; ipecac. pulv., grs. xxx; pulv. capsicum, grs. 80. M. Make into 30 pills. Take one every three hours with water slightly acidulated with muriatic acid. We have not failed on a case using this.—*Atlanta Medical Journal*.

To Hasten the Action of Quinine.

Dr. STARKE, in *Berliner Klin. Wochenschrift*, advises that before swallowing powder or pills of quinine, a weak tartaric acid lemonade be taken. This procedure not only greatly accelerates the solution and absorption of the quinine, rendering its physiological action much more prompt, but also obviates that unpleasant gastric irritation so common after the administration of large doses of this drug.

Amyl Nitrite for Ague.

Dr. SAUNDERS, of Indore, India, reports in the *Indian Medical Gazette* a number of cases of ague successfully treated with amyl nitrite. He asserts that in every instance the disease yielded quickly and permanently to the amyl

treatment. He mixes the drug with an equal volume of oil of coriander, to make it less volatile and to cover its odor, and administers it as follows: Four drops of the mixture are poured on a small piece of lint, which is given into the hands of the patient for him to inhale freely; he soon becomes flushed, and both his pulse and respiration are much accelerated, and when he feels warm all over, the inhalation is discontinued, as the symptoms continue to increase for some time afterward; a profuse perspiration now sets in, which speedily ends the attack, though in some cases the cold stage merely passes off without any hot or sweating stage.

Petroleum in Diphtheria.

Dr. LAMARRE, of Saint Germain, has lately employed petroleum oil topically, with very encouraging results in an epidemic of diphtheria. Archambault has tried it in the Children's Hospital, but without any obvious advantage. In two severe cases it was used, with the result that one died and the other recovered. In the case which recovered there were albuminuria, engorgement of the cervical glands, and nasal diphtheria. Petroleum is a rapid solvent of the false membrane, and must possess distinct advantages under some circumstances. This fact, coupled with its antiseptic property, renders it a promising remedy, although its odor always renders its use disagreeable. It has accomplished sufficient results to justify its further use. We believe that it has been applied more or less in this country, but we are not aware of any published results of the treatment.—*Medical News*.

Antidiphtheritic Inhalations.

Some years ago, Dr. H. HAGER recommended a mixture composed of carbolic acid, 10 parts; alcohol, 10; water of ammonia, 12; distilled water, 20, as an excellent inhalation in catarrhal affections. It was directed to be used thus: A small wide-mouthed bottle was to be filled one-third with the liquid; then a sufficient quantity of cotton was to be introduced to just soak up all the liquid. The bottle was then to be well stopped. In coryza, incipient catarrh, or similar affections, the inhalation through the nostrils of some of the vapor of the compound was found to be of the greatest benefit.

The same author now recommends a still stronger compound, to be made from carbolic acid, 10 parts; oil of turpentine (or oil of eucalyptus), 5 parts; water of ammonia, 12 parts; alcohol, 20 parts. A small quantity of this is to be dropped into a small wide-mouth bottle half filled with cotton or asbestos, and the bottle well stopped. After a few days a little more may be added, until a strong odor is given off, when the bottle is opened.

A physician to whom Dr. Hager recommended the use of the compound thinks that it prevents the spread of diphtheria, since in five families, in each of which one case of diphtheria had become developed, its further spread was arrested, apparently through the use of the antiseptic inhalation. In another family, a second child was taken with the disease; but the child could not be coaxed to inhale the vapor. The inhalations should be as full and deep as possible. In some cases of coryza, it has been used with most excellent effects.

Should the odor of oil of turpentine be too offensive to any person, oil of eucalyptus may be substituted for it.—*Mich. Med. News*.

Diphtheria: Its Etiology and Treatment.

Dr. H. L. GETZ, (*Medical and Surgical Reporter*.) Concerning the seat of the disease there can be little doubt; nay, there can be no doubt in the minds of those who have had experience with the disease, that if it is not a constitutional disease at the outset, it very soon becomes such. And if the disease is communicable through drinking milk, etc., while micrococci may attach to the fauces and tonsils, and thence originate the disease, it is quite as likely that some may be and are carried into the stomach, and so on into the circulation. And in such an event it would be possible for the disease to be sometimes first constitutional and at others first local. In either event, if the disease germs are lodged anywhere in the system, local or otherwise, the constitutional and the local symptoms will soon be manifest; so that the treatment resolves itself into local and constitutional, from the outset. At any rate, this is the only safe mode to adopt. In some instances, if the disease were purely local (which I believe it may sometimes be), and we had some means by which we might to a certainty settle this point, we might then adopt a purely local treatment, perhaps with success, if the cases were recognized in their incipency; but having no such means we must be alike prompt in local and constitutional treatment, if we would save our patient, for delay in either is almost certain death.

My experience and observation extend over a period of eight years. I have seen the disease in its various stages and types. If you begin treatment within twelve hours from the onset of the disease (membrane formation) the patient with proper treatment will recover.

If you begin treatment twelve to eighteen hours from the onset of the

disease you may expect to lose a patient occasionally.

If you begin treatment from eighteen to twenty hours after the onset of the disease you may expect many fatal cases.

The disease is one which usually runs a rapid course; the patient dying in from four to six days, mostly. I have seen cases perish in forty-eight hours where no treatment had been given.

This being the case, it is evident that to accomplish anything satisfactory the treatment must be prompt and thorough; the patient must have the same attention night and day, until you have the disease thoroughly under control.

I rely upon the following plan of treatment (having tried many other modes and abandoned them because not reliable): pure air, of proper temperature; quinine and iron, in form of elixir, in tablespoonful doses every two hours for an adult; proper nourishment—extract of beef, milk; eggs, good port or sherry wine.

Locally, internally, tincture of iron with glycerine, in the proportion of two parts of the former to one of the latter, and this mixture saturated with chlorate of potass.; this should be thoroughly and carefully applied every six hours, to the fauces, tonsils, etc., by the physician, and never entrusted to inexperienced persons. A gargle consisting of one part of the above mixture and three parts of water should be used every two or three hours. Small pieces of ice may also be allowed to dissolve in the mouth to good advantage when not annoying to the patient.

Locally, externally, nothing, except where there is swelling of the lymphatics; then the application of lin. ammon.

If the above plan of treatment is faithfully carried out I know that the mortality of this much dreaded disease will be very much lessened.

DISEASES OF THE NERVOUS SYSTEM.

Treatment of Aggravated Hysteria and certain allied forms of Neurosthenic Disease.

DR. W. S. PLAYFAIR concludes an interesting and quite exhaustive article on this subject as follows :

The principal elements in the systematic treatment of these cases are—

1. The removal of the patient from unhealthy home influences, and placing her at absolute rest.

2. The production of muscular waste and the consequent possibility of assimilating food by what have been called "mechanical tonics;" viz. : prolonged movement and massage of the muscles by a trained shampooer, and muscular contractions produced by electricity.

3. Supplying the waste so produced by regular and excessive feeding, so that the whole system, and the nervous system in particular, shall be nourished in spite of the patient.

On each of these I shall offer one or two brief observations :

1. The removal of the patient from her home surroundings, and her complete isolation in lodgings with only a nurse in attendance, is a matter of paramount importance. This is a point on which I am most anxious to lay stress, since it is the great crux to the patient and her friends ; and constant appeals are made to modify this, which I look upon as an absolute *sine qua non*. I attribute much of the success which I have been fortunate enough to obtain in my cases to a rigid adherence to this rule. In almost every instance of failure in the hands of others of which I have heard, some modification in this rule has been agreed to, in deference to the wishes of the friends ; as, for example, treating the case in one room by herself in her own house, or in admit-

ting the occasional visits of some relatives or friends. While, however, the patient is to be rigidly secluded, it is incumbent to secure the attendance of a judicious nurse, with sufficient intelligence and education to form an agreeable companion. To shut up a refined and intellectual woman for six weeks with a coarse-minded stupid nurse, can only lead to failure. I have had more difficulty in obtaining suitable nurses, sufficiently firm to ensure the directions being carried out, and yet not over-harsh and unsympathetic, than in any other part of the treatment. Whenever my case is not doing well, I instantly change the nurse—often with the happiest results. In addition to the isolation, the patient is put at once to bed, to secure absolute rest. In many cases she is already bed-ridden ; in others there has been a weary protracted effort, and the complete repose is in itself a great gain and relief.

2. Under the second head comes systematic muscular movement, having for its object the production of tissue waste. This is administered by a trained rubber, and here again is a great practical difficulty. The so-called professional rubbers are in my experience, worse than useless, and I have had to teach *de novo* a sufficient number of strong, muscular young women ; and the aptitude for the work I find to be very far from common, since a large proportion of those I have tried have turned out quite unsuited for it. I cannot attempt any description of this process. I need only say that it consists in systematic and thorough kneading and movements of the whole muscular system for about three hours daily, the result of which at first is to produce great fatigue, and subsequently a pleasant sense of lassitude. Subsidiary to this is the use of the faradic current for about ten to twenty min-

utes, twice daily, by which all the muscles are thrown into strong contraction, and the cutaneous circulation is rendered excessively active. The two combined produce a large amount of muscular waste, which is supplied by excessive feeding; and in consequence of the increased assimilation and improved nutrition, we have the enormous gain in weight and size which one sees in these cases, it being quite a common thing for a patient to put on from one to two stones in weight in the course of five to six weeks. The feeding, at regular intervals, constitutes a large part of the nurse's work. At first from three to five ounces of milk are given every few hours; and for the first few days the patient is kept on an exclusive milk diet. By this means dyspeptic symptoms are relieved, and the patient is prepared for the assimilation of other food. This is added by degrees, *pari passu* with the production of muscular waste by massage, which is commenced on the third or fourth day. By about the tenth day the patient is shampooed for an hour and a half twice daily, and by this time is always able to take an amount of food that would appear almost preposterous, did not one find by experience how perfectly it is assimilated, and how rapidly flesh is put on. It is the usual thing for patients to take, when full diet is reached, in addition to two quarts of milk daily, three full meals, viz.: breakfast, consisting of a plate of porridge and cream, fish or bacon, toast and tea, coffee and cocoa; a luncheon, at 1 P. M., of fish, cutlets or joints, and a sweet, such as stewed fruit and cream, or a milky pudding; dinner at 7 P. M., consisting of soup, fish, joints, and sweets; and, in addition, a cup of raw meat soup at 7 A. M. and 11 P. M. It is really very rare to find the slightest inconvenience result from this apparently enormous

dietary. Should there then be an occasional attack of dyspepsia, it is at once relieved by keeping the patient for four and twenty hours on milk alone.

Such is a brief outline of the method to which I am here to direct your attention. As to the results, I have already published several remarkable illustrative cases, so that it is perhaps not necessary to do much more in this direction. I may say, on looking back at my cases, that the only ones with which I have any reason to be disappointed are those in which the primary selection has been bad; and in the few in which the results were not thoroughly satisfactory, I had doubts as to their suitability for the treatment, which I expressed beforehand. These include one case of chronic ovarian disease, and one of bad ante flexion with fibroid enlargement of the uterus, in both of which the local disease prevented any really beneficial results. In a third I had to stop the treatment in a week, in consequence of cardiac mischief; two others were cases of positive mental disease; and in one case there was true epilepsy. I have no doubt that any positive co-existent organic disease of this kind should be considered a contraindication. In my other cases the results have been all that could be wished, and in many of them the patients have been restored to perfect health after having being helpless bedridden invalids for years; in one case twenty-three without ever putting a foot to the ground, in others sixteen, nine, six, and so on. In two instances my patients were in such a state, that it was found absolutely impossible to move them except when anesthetized; and they were brought to London by the medical men long distances under chloroform, in each case leaving in six weeks perfectly cured.

Hysterical Spine.

There is a form of backache in which, according to Dr. VINCENT (*Medical Press and Courier*), pressure does not increase the pain, but rather relieves it. There is no tenderness elicited by pressure with the open hand along the spine, but, on the contrary, if the finger be drawn lightly along the spinous processes, marked evidences of pain are noticed. On tapping the spine with the finger, the same cringing and flinching of the patient will occur, enabling the soreness to be localized. This is very apt to be in the lumbar region, especially if any uterine irregularity exist. There is great weakness of the muscles accompanying this condition, and the back is limp and bent. The prognosis is good, especially in the younger cases. Support, systematic exercise with the trapeze, the cold douche to the spine, or with the sponge, followed by friction, and moral treatment, are especially relied upon. Drugs are of little use, but the bitter and more unpleasant mixtures are preferred, in order to supply the patient with an inducement for getting well.—*Med. Times.*

Writers' Cramp.

The *British Medical Journal* in an article on the above subject, considers that writers' cramp, although counted among minor nervous disorders, has probably given rise to quite as much discomfort, and even hardship, as some of those considered more important. Many expedients have been tried to relieve it, such as a thick penholder, metal plates attached to the penholder, besides such severe measures as myotomy, tenotomy and nerve-stretching. The treatment recommended at present is absolute cessation for a prolonged period from all attempts at writing, the

use of the constant current and a well-directed exercise of the muscles, with a general tonic treatment. Professor Nussbaum, of Munich, set himself to contrive a penholder that would be directed by the extensors and adductors, instead of the flexors and abductors, because there is always a spastic contraction of the flexors and abductors with a weak condition of the extensors and abductors. He made a bracelet of a stiff band of gutta percha, oval in shape, about one-eighth of an inch thick and one and a fourth inch broad, having a long diameter of about three and three-fourths inches, and a short one of one and a fourth inch. In using it the thumb is only just entered, the fourth finger is entered almost as far as it will go, and the little finger is left outside. The bracelet can be held firmly only by expanding the fingers strongly, that is by the use of the extensors of the first four fingers, and the abductor of the thumb. The pen is screwed to this bracelet, so as to be in contact with the paper when the hand lies on the table. Professor Nussbaum says that a number of cases treated by him wrote at once easily and distinctly with this instrument, not a trace of spasm appearing in any of them. This method of treatment is extremely simple, and has this very strong recommendation in its favor, that in place of the patient being forbidden to write, he is encouraged to write with the instrument as much as he possibly can in order thereby to strengthen the antagonists of the muscles liable to spasmodic contraction.—*Chic. Med. Review.*

Misleading Symptoms of Serious Cerebral Disease.

The *British Medical Journal* reports an instructive case that occurred in the London Hospital. A boy, aged 15, div-

ing into the river, struck his head on the bottom. Upon admission he was dull, semi-unconscious, complained only of headache, and seemed to be suffering from slight concussion of the brain. Rest and ice to the head was the treatment. In three days he was well enough to go home, but in the evening (before being discharged) was attacked with severe headache, pupils dilated, no paralysis, and speech became difficult. There was now noticed a slight purulent discharge from the ear. These symptoms increased, and the boy, becoming comatose, died the fifth day after admission.

One of the patients in the ward was told by the father of the boy that a discharge had been present before admission, for which he had been under treatment outside, and also that he had previously suffered for some time with headache. This was the first intimation that the boy had been out of health, notwithstanding inquiries made of the friends.

On *post-mortem* examination, the dura mater was found adherent to the brain posteriorly. In the left parietal and temporal region was a blackened spot covering a large abscess-cavity reaching so far as, though not entering, the ventricular space, and containing a considerable quantity of very foul pus. The temporal bone was necrosed, and pus found between that bone and the dura mater.

The coincidence of the injury and the brain-mischief is obviously of much interest, as, supposing the boy had been allowed to go home and then died, it would have been impossible to convince his friends that his death was not due to the injury, and that there had been culpable want of care.—*Medical and Surgical Reporter*.

The Ether Spray an Immediate Cure for Neuralgia.

Dr. MCCOLGANAN extols the value of the ether or rhigolene spray for the instantaneous relief principally of facial neuralgia. He first had occasion to observe its good effects upon his own person, he having suffered greatly from facial neuralgia. Since curing himself, he has had occasion to test its efficacy in about twenty cases. The result was invariably a most gratifying success. In many instances a permanent cure was established. He attempts to explain its action by supposing a complete change to take place in the nutrition of the affected nerve in consequence of the intense cold acting as a revulsive.—*Southern Practitioner*.

The Mechanical Treatment of Neuralgia.

The author (Dr. E. RASORI) uses the tuning-fork in the treatment of neuralgic pains, applying its vibrating over the course of the painful nerves. He reports the experiments of Boudet, who, by means of the tuning-fork, could check a neuralgia for some time. Boudet used the instrument in accordance with the ideas of Granvill, who thought the neuralgia consisted in a peculiar vibration in the nerve trunk, to induce different vibrations in the painful nerves. He mentions many other experiments from Bal, of Paris, and Renzer and Growers, of London, where the application of the instrument was of benefit.

The instrument was applied for from twenty to forty minutes when the patient was relieved without further treatment. During the neuralgic attacks one of the women had suffered from vomiting, but after the relief from the application she was troubled no more in this way.—*Bollettino della Societa Hancisiana, Roma*.—*Cincin. Lancet and Clinic*.

DIGESTIVE TRACT.

Milk Powder in Gastric Affections.

The *Medical Times and Gazette* says that Dr. DEBOVE, in a communication to the Paris Hospital Medical Society (*Gaz. Hebdomadaire*, August 25), observes that the milk regimen, which is so indispensable in affections of the stomach, and especially simple ulcer, speedily becomes so disgusting to these patients that it has to be left off. This serious inconvenience, however, may be remedied by the employment of the œsophageal tube now used for feeding phthisical patients. But by this only a litre of milk can be introduced at a time, so that it would require to be employed six times in order to introduce the six litres, which is the mean quantity required for the subjects of *ulcus rotundum*. To avoid this frequent introduction of the tube, Dr. Debove has had skimmed milk evaporated (cream being but slightly digestible), and the residue reduced to a fine powder. If this be dissolved in warm hot water, two or three litres of milk may be injected in the same volume as a single litre. It is possible that this milk-powder, which furnishes excellent results in gastric affections, may also prove very useful in Bright's disease, cardiac affections, and all cases in which a milk regimen is employed. About a litre of pure milk is represented by 4 ounces of the powder. Dr. Dujardin Beaumetz observed that in feeding the subjects of phthisis with the tube he has obtained excellent results from a mixture of powder of meat, powder of blood, and powder of milk. As powder of blood is not very digestible, he only adds a small proportion of that as a ferruginous principle.—*Med. and Surg. Reporter*.

Atropin for Dribbling from the Mouth.

Dr. G. F. YEO says in the *Lancet*, that often, in cases of paralysis, and sometimes in fracture of the skull, dribbling from the mouth is a most distressing symptom; it saturates the pillow and robs the poor patient of much needed sleep. A little atropin injected under the skin in the neighborhood of the gland, checks for hours the flow of saliva and enables the sufferer to enjoy a quiet sleep.—*Ibid*.

Alcoholic Gastro-Enteritis.

M. LENDET, of Rouen, read a paper upon alcoholic gastro-enteritis, before the French Association for the Advancement of Science. His conclusions were:

First.—The lesions of the alimentary tract due to the use of alcohol are generally present in stomach and intestine, but they may be more localized.

Second.—The quality of alcohol consumed contributes less than the mode and amount in which it is taken to determine the resulting form of disease.

Third.—They present different forms in different classes of society.

In the better classes alcohol is taken, perhaps, oftener, but in smaller quantities. Among laboring men alcohol is taken in large doses at rarer intervals.

Fourth.—In the better classes the form of gastro-enteritis is the catarrhal, and it is mild and chronic.

In the workmen it is often an acute, subacute, or chronic gastro-enteritis.

Fifth.—Nervous and mental troubles result equally in both classes.

Sixth.—Hepatitis and vascular troubles are relatively more frequent, but more chronic in the better classes.—*Ibid*.

The Microscope in Diarrhœa.

A number of cases of diarrhœa occurring together, when hot weather had been followed by rain, the epidemic was

studied by Mr. K. W. Millican (*Lancet*) with the aid of the microscope. A short period of incubation occurred, during which the patients were depressed and out of sorts, and this was followed by a prostrating attack of diarrhœa. The stools were fluid, not unlike those of typhoid fever, and contained in every instance small gelatinous or albuminous lumps like half-cooked white of egg. The odor was extremely offensive. Beyond the prostration, however, the general gastric disturbances, with excessive flatulent distention and pain, there were no constitutional symptoms. In no case was there any marked rise of temperature, nor was the pulse greatly affected.

The lumps of gelatinous material were submitted to microscopic examination, with the result of detecting large numbers of bacteria, in granules, short fine rods, long fine-pointed rods, and curled twisted ones; and also mycelial threads. The method of examination pursued was to allow some of the gelatinous material to dry on the slide, float it on analine blue solution until stained, then wash with nitric acid, and finally in distilled water; the slide was then dried, and mounted in Canada balsam. The $\frac{1}{8}$ or $\frac{1}{4}$ inch objective was sufficient to detect these organisms.—*Med. Times*.

Koroniko in Chronic Dysentery.

The Practitioner quoting from the Chinese Imperial Maritime Customs Medical Reports gives the value of the above named drug in dysentery, which was very prevalent in that community during the Autumn of 1880. Acute dysentery had generally become sub-acute or chronic before the patients applied at the hospitals, so that the chronic form had generally to be treated. As every one knows, these are the difficult cases to influence speedily by drugs, and with the Chinese a change of air or sea

voyage is out of the question. In these cases Dr. Jardine was induced to try koroniko, from the veronica parviflora, which is largely used in New Zealand as a remedy in dysentery and diarrhœa, and some of the results exceeded his most sanguine expectations. Many who received the drug did not return to report themselves, but he has notes of three cases of chronic dysentery, varying in duration from six weeks to four years, and voiding from twenty to thirty motions containing blood and mucus daily. Fifteen doses of tinct. koroniko reduced them to one half, fifteen doses more reduced them to three or four daily and a third like quantity effected a complete cure. Judging from the few cases he has been able to follow, he predicts a brilliant future for this remedy in the chronic forms of the disease.—*Chic. Med. Review*.

The Treatment of Tape-Worm.

Dr. BERENGER-FERAUD, in the *Bulletin Générale de Thérapeutique* (August 15), communicates the results of the various kinds of treatment for the removal of the unarmed tape-worm, obtained by him at Cherbourg and elsewhere. He reports a decided increase in the number of cases of this kind applying for treatment. As to his results, he states that out of more than a thousand cases under observation, he found that about 79 per cent. had but one parasite, 13 per cent. had two, 5 per cent. had three, and only 3 per cent. had a greater number. From several methods of treatment, he gives the following as the results of his observations.

Spirits of Turpentine.—Out of eight cases in which this was administered, one only occurred in which the head of the worm was discovered. The remedy was complained of by the patients on account

of its producing digestive disturbance and its being extremely disagreeable to take. He regards this method, therefore, only as a palliative, and, as large doses are not without danger, recommends that it be definitely renounced.

Male Fern.—The number of his cases is so small in which this was used that although they were sufficiently successful to give great confidence in the remedy, no final conclusion was warranted, but further experiment was regarded as needed to determine its value.

Pumpkin Seed.—In thirty cases in which this remedy was given, complete success occurred but once, but in twenty-eight others more or less of the worm was expelled without the head. From a larger number of observations it was concluded that this method succeeded completely in about 5 per cent. of the cases.

Koosso.—This was employed in two hundred and three patients, but in eighteen the result was not known. Out of the remainder, there were twenty-two complete successes, one hundred and twenty-six expulsions of worm without the head, and in thirty-nine there was failure.

Pomegranate-root bark gave about 45 to 50 per cent. of successes in about four hundred cases; but *pelletièrene tannate* he regards as the most powerful tæniacuge which we possess, as the worm was completely expelled in 76 per cent. of the cases in which it was used. The following details of administering the remedy (*Tanrets pelletièrene*) were those adopted by the author, by whom they are considered important, in order to secure the desired result :

"The subject, on entering the hospital, is put on ordinary diet until the presence of the tape-worm joints are discovered in the stools. This proof having been obtained, he is put upon a

milk diet,—that is to say, three quarts of milk, and, if needed, about 300 grammes (10 oz.) of bread, for two meals. On the next morning at six o'clock there is given to the patient (who should remain lying in bed during the administration of the tæniacuge) an infusion of 10 grammes of senna-leaves in 100 grammes of water sweetened with 30 grammes of syrup of orange-peel. At seven o'clock the patient takes half the dose of pelletièrene diffused in twice its weight of water, in order that too great a quantity of the medicament shall not rest in contact with the sides of the worm. At seven and a half o'clock the second half is to be given, and the bottle which contained the pelletièrene rinsed out with about 10 grammes of water, which is also to be swallowed.

"The patient, still remaining in bed, should close his eyes and keep quiet, to avoid nausea and vomiting. At eight o'clock, if there is no sickness, or a little later, after the nausea has stopped for a while if it had manifested itself, 30 or 40 grammes of castor oil emulsified with spirit of peppermint (10 grammes) and sweetened water (20 grammes) are to be given.

"If an hour after the ingestion of the castor oil there has still been no stool, a large emollient lavement is to be given, followed, if need be, by a purgative enema (15 grammes of senna-leaves, 30 grammes of sulphate of soda, and 300 grammes of water), and, finally, large emollient injections, in order to solicit the intestines to defecation without delay.

"The subject places himself for evacuation upon a vessel half-full of water, with directions not to draw upon the worm in case it is only partly discharged at first. In this event the attendant should give a large injection, endeavoring not to break the worm, in

order to facilitate its complete expulsion."

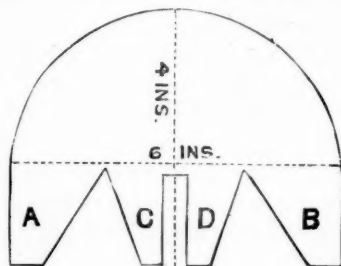
Generally, in one hour after giving the castor oil, a large stool is obtained, in which the chances are that the worm will be expelled entire; sometimes it does not appear until the second or third discharge. It may be necessary to increase this dose of senna and oil when patients are known to be difficult to purge, or a second dose of oil may be given at noon. The greatest importance in this scheme of treatment, for success, is attached to the rapidity as well as the energy of the purgative.—*Med. Times.*

DISEASES OF THE RESPIRATORY ORGANS.

Antiseptic Treatment of Pulmonary Consumption.

In view of the causal relations of bacilli to this disease and the affirmed constant presence of the micro-organisms in the matter expectorated, the use of antiseptics or germicides becomes an essential element of treatment not only with reference to the patient, but also to those who may be subjected to the possibility of infection. Dr. I. BURNEY YEO, physician to King's Col. Hosp., in a clinical lecture in the *British Medical Journal* of July 1st, refers to the beneficial effects of antiseptic inhalations, and proposes a simple and cheap inhaler, the figure of which we have copied from his lecture. The advantages of such a method over the spray apparatus are obvious, since it permits an almost continuous use of the remedy. This respirator, Dr. Yeo states, costs, practically, nothing; a dozen can be made for less than a shilling, and with a little instruction any one can make one in a few minutes. The following is Dr.

Y.'s method of making it: Take a piece of paper six inches long and four inches wide; fold along the middle and cut with a pair of scissors into this form:



Place this on a piece of perforated zinc, which will cost about a sixpence a square foot, and with scissors cut out a piece of the zinc of the same size and form as the paper. Now by a little manipulation bring the two outer ends (A and B) together so as to slightly overlap; then fixing these together with a twist of fine wire passed through the holes of the zinc, you get a suitable mouthpiece, or rather nose and mouthpiece, for it is important to cover both nose and mouth. It can be bent to fit comfortably any face. The two middle pieces (C and D), which now stick out behind, can be gradually bent down, first one, then the other, over it, so as to construct a cage behind the mouthpiece, which will hold a small bit of sponge, tow, cotton-wool, or other suitable material for retaining the antiseptic vaporizable fluid. It is desirable to cover the rough end of the mouth and nosepiece with some protecting material, it matters not what; he uses tin-foil; a loop of elastic on each side serves to attach it behind the ears. It may be covered with black silk or other material, according to taste, although this is not necessary. This apparatus costs so little that it can be given to hospital and dispensary patients. It is light and

comfortable, and patients find no difficulty in sleeping with it on. Dr. Yeo prefers creasote as the antiseptic, and says it is rarely necessary to use more than ⅓xx. of a mixture of equal parts of creasote and sp. chloroform dropped on the sponge and renewed occasionally as it becomes exhausted. It is often desirable to begin with very small quantities (as 5 drops) until the patient gets used to the vapor. Turpentine is a useful addition when there is a profuse secretion or a tendency to hemorrhage. One of the advantages of this inhaler is that, being perforated all over, access of air is unimpeded, while the vapor diffuses itself freely into the immediately surrounding atmosphere. Creasote is also given internally by Jaccoud, of Paris, who calls it a "precious medicine," and says it forms a "fundamental part" of his treatment. He gives it in cod-liver oil or glycerine. Lemaire also reports remarkable effects from the internal use of carbolic acid. — *Maryland Medical Journal*.

Sulphurous Acid in Consumption

Most readers are aware that sulphurous acid is one of our most important bacillicides, and the more to be recommended, as it can be inhaled with impunity. Mr. Julius Kircher, a pupil of Liebig, and owner of a chemical factory in Brooklyn, writes as follows to the *Zeitsch. f. d. astr. Apoth. Verein*.

The observation of Koch has found a brilliant confirmation in my factory, where a large quantity of sulphur is evaporated daily. That in this process a great deal of sulphurous acid is formed can easily be imagined. During the forty-four years that my factory has existed none of the many laborers have ever been affected by tubercular consumption, nay, more, frequently enough persons in the beginning stages of this

disease applied for admittance and were cured within a few weeks, simply by inhaling the sulphurous acid. If not too far progressed, these individuals become strong, stout, and perfectly healthy again.

All diseases zymotic in character, even cholera, stay away from this factory and those working there. Persons affected with bronchial catarrh are rapidly cured.

Phthisical patients should live in rooms where hourly 1 to 2 drachms of sulphur are evaporated on a warm stove. First eight or ten days there is increased irritation of cough and expectoration: then these cease, and the individual rapidly improves. Convalescents should live for a time in rooms filled with aromatic watery vapors. — *Med. and Surg. Reporter*.

Cough of Phthisis.

Dr. ALONZO CLARK, in a recent clinical lecture, published in the *Medical and Surgical Reporter*, gives a very useful point in controlling the cough of phthisis, or at least bringing it within bounds. He directs that two grains of the extract of opium, which has been dissolved before, be dissolved in three ounces of water, and if desirable, a small quantity of glycerine may be added. The solution is to be placed in an atomizer. The spray is to be inhaled seven or eight times in succession, and repeated as necessary. — *Chicago Med. Review*.

Treatment of a Cold.

The following is recommended by M. VIGIER as a pectoral in place of the nostrums so commonly used: R. Syrup. adianti (*s. capillaire*), 200 grm.; ext. opii, 0.10 grm.; ext. hyoscyami, 0.20 grm.; ext. aconiti [aq.], 0.30 grm. Dissolve the extracts in distilled water

(about 3 or 4 grms.), filter, and add the syrup. This is to be taken in tablespoonful doses three or four times daily. —*La France Méd.*

How Far may the Alcohols be Used in the Treatment of Pneumonia ?

In the treatment of either croupous or catarrhal pneumonia, alcohol must, by all means, be used with caution. There are, for example, cases of pneumonia where the employment of alcohol to prevent paralysis of the heart, not only disturbs the regular course of the disease, but has a directly injurious tendency. This is to be noticed:—1. In all light cases of pneumonia. By this we mean those cases in which the temperature does not rise above 104°, where the dyspnoea is not very great, where the pulse is strong and the pulmonary trouble in general shows no tendency to rapidly increase. The employment of alcohol in such cases can only have a dangerous effect, for through the increased action of the heart more blood is thrown to the lung and the disease is increased. 2. The above treatment of pneumonia is further contra-indicated in people who are otherwise strong and healthy, who have not passed forty-five years of age. In children and young people alcohol exerts no favorable influence on the course of the disease. 3. In those cases of pneumonia where there is a valvular lesion of the heart alcohol is to be avoided; for through the increased action of the heart collapse is sooner to be expected. On the other hand, indications for the alcohol treatment are:—1. In those patients in whom there is thought to be a degeneration of the heart muscle, but when there is no valvular lesion. This is mostly the case in chronic alcohol drinkers, in whom an unexpected paralysis of the heart may occur at any time. 2. In those who

have passed fifty years of age, if they possess no heart lesion. 3. In the so-called hypostatic pneumonia where the appeal impulse is in position, for the purpose of supplying the sound as well as the diseased lung with fresh, healthy blood, and to protect the sound parts of the organ from stasis and the diseased part from the further consequences of the stasis which has already occurred. 4. In every pneumonia, if only the heart is not affected with a lesion of the valves, after the crisis has passed, so as through the increased impulse to the circulation to more rapidly promote the absorption of the exudation. 5. Finally, alcohol cannot be avoided without regard to the condition of the heart in persons having a tendency toward collapse, where paralysis of the heart or oedema of the lungs may occur at any moment. When, however, oedema is already present, then alcohol is no longer of use, for by this means will the patient, who is now without hope, be unnecessarily maintained in the death-agony. The thoughtless, unrestricted treatment of every case of pneumonia with alcohol is not only unscientific, but indeed blamable.—*Cincinnati Lancet.*

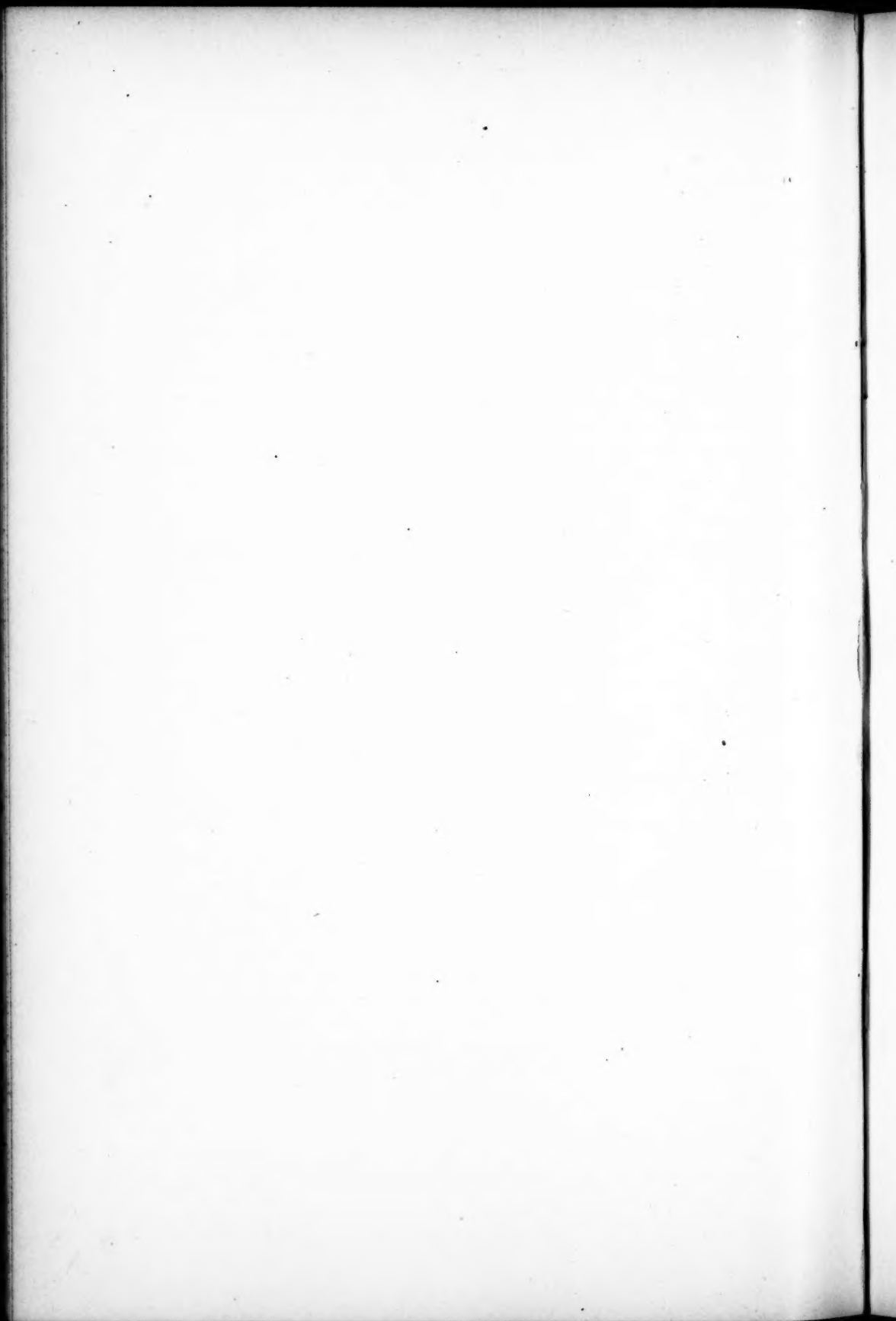
Ether Inhalations in Angina Faucium.

In the *Riv. Clin. di Bologna*, Prof. CONCATO recommends ether spray as an inhalation in sore throat. The patient takes the exit tube of Richardson's spray-producer in his mouth, and sulphuric ether is sprayed against the pharynx for three hours. Six cases were cured without other remedies. Each case began with a rigor and a sharp attack of fever, temperature 104° F. There was swelling of the sub-maxillary gland, and pain and difficulty in swallowing. The tonsils were swollen and protruding.—*Medical and Surgical Reporter.*

THE AMERICAN MEDICAL DIGEST.

PART II.

SURGERY.



SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

An Improved Method of Treating Depressed Fractures of the Nasal Bones, with Report of Six Cases.

By LEWIS D. MASON, M.D., Surgeon
to Long Island College Hospital.

Since the announcement of my method of treating these fractures, cases in point have from time to time been sent to me by different practitioners with flattering reports of their results, and this has led me to again present to the profession some of the more *important of these cases*, and for the benefit of those who may not be familiar with the method of treatment, herewith preface the cases with an epitome of the treatment with plates. An ordinary three-cornered surgical needle of medium size, ground to a drill point, and nickel plated to prevent



FIG. 1.—Showing needle passed beneath nasal bones.

corrosion, is passed so that it shall afford not only a posterior support to the nasal bones, but also act as a tie-rod, holding together the sides of the nasal arch.

After proper elevation of the depressed fragments, the needle is passed usually through the line of fracture of the nasal processes on either side (Fig. 1).

The line of fracture can be readily felt before inserting the needle, or can

be searched for subcutaneously with the point of the needle. By thus supporting the fractured nasal processes, we sustain the nasal bones, which rest upon them. Should the line of fracture not prove symmetrical, we can drill through the nasal processes on either side, at such points as circumstances may dictate. Under any conditions the needle will

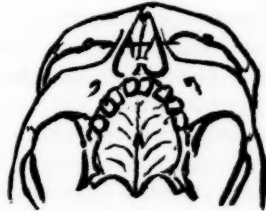


FIG. 2.—Showing course of needle as viewed from below, looking up into nasal cavities.

have three points of support; the nasal processes on either side and the nasal septum (Fig. 2). To complete the dressing, a small strip or ribbon of pure rubber bandage is placed over the bridge of the nose (Fig. 3), giving the rubber suffi-



FIG. 3.—Showing rubber tape passed over bridge of nose, and fastened by needle thrust beneath nasal bones, exerting lateral support.

cient tension to exert a gentle downward and lateral compression, but not enough to interfere with the circulation of the part, or to exert an injurious degree of pressure on the fragments. As soon as

consolidation is sufficiently advanced to sustain the fragments, the needle may be withdrawn. Anæsthesia will be necessary during the manipulation for the restoration of the arch, and passing of the needle.

CASE FIRST.—J. G., aged 14, U. S., fell from a wagon, striking upon his forehead and face, sustaining a contused and lacerated wound of forehead—the upper lip on the left side being torn away from its nasal attachments—the principal injury being a compound and comminuted fracture of nasal bone and nasal processes of superior maxillæ. The line of fracture of left nasal process was near its base, on the right side, near its middle. The bridge was very much depressed and flattened; the right nasal bone was lateralized to the right and made a small puncture through the skin on that side. Viewed from either side the deformity was very great, the end of the nose being at right angles to the depressed bridge. After elevating the depressed fragments and overcoming the deformity as much as possible, I passed an ordinary surgical needle through the line of fracture on either side, thus supporting the nasal arch. To complete the dressing, a piece of thin rubber about half an inch wide was slipped over the head and point of the needle, and rendered moderately tense, so as to exert a gentle compression; small pieces of cork were placed on the head and point of the needle to protect the face. Evaporating lotions were applied to face and nose over dressing. The case progressed favorably until the eleventh day, at which date the needle was easily removed without anæsthetic. The contour of the nose was excellent and much better than anticipated, and the boy breathed well through his nostrils. At no time during the operation was there any pain or uncomfortable sensation at

seat of needle. The result may be said to be perfect.

CASE SECOND.—C. B., U. S., aged 27, truckman. He had fallen from the seat of his truck, some eleven feet, upon the pavement. He was intoxicated at the time. The force of his fall was received upon his face, producing a comminuted fracture of the nasal bones, and also fracturing the nasal processes of the superior maxillæ. There was also a lacerated wound of the right inner canthus, and a contused and lacerated wound of the forehead. Serous infiltration of the tissues were present in a marked degree, but not enough to completely mask the deformity, flattening of the bridge being quite apparent. A probe introduced into the superior meatus demonstrated that the space was encroached upon by the broken fragments. Marked crepitus with free lateral motion of the nasal processes was present. The depressed bridge was elevated in the usual manner, care being taken to restore the full calibre of the superior meatus by lateral as well as forward pressure of the probe. The restoration was easily effected, the contour of the bridge being readily traced with the finger. As no special line of fracture could be determined, owing to the extensive comminution and swelling, the needle was passed as nearly as possible through the base of the nasal processes between the comminuted fragments, not meeting with any resistance. A ribbon of thin rubber was passed over the nose, made moderately tense, and the ends fastened to the point and head of the needle by puncture. Over all a wet cloth with evaporating lotion was applied. An anæsthetic was not necessary during the passing of the needle, the patient being in a state of partial alcoholic coma. The needle was withdrawn about the tenth day following the opera-

tion. Considerable suppuration resulted from the wounds on the forehead and inner canthus. With this exception the case progressed favorably, with a good result.

CASE THIRD occurred in practice of Dr. C. B. Nancrede, of Philadelphia. A German, aged 45, sustained an extensive compound comminuted fracture of the nasal bones and the nasal processes of the superior maxillæ, involving also the nasal spine and eminence of os frontis, and possibly a displacement of the vertical plate of the ethmoid. The injury resulted from the kick of a horse. The bones were extensively comminuted. Not having a proper pin at hand, I passed a long insect pin between the hindermost fragments and what remained of the nasal processes of the superior maxillæ. A strip of ordinary adhesive plaster, having a slit for the head of the pin, was then passed over the bridge of the nose, and the pin's point forced through the other end. A wet dressing was applied, and rest in bed enforced. At the end of the fifth or sixth day the pin was removed. Before the removal of the pin the nose was occasionally moulded by my fingers or those of my assistant. When the patient was discharged his nose had certainly as good an appearance as if no injury had been sustained.

CASE FOURTH.—Dr. Fifield, of Boston, has reported the following case: "A boy, aged 9, fell from the roof of a freight car, striking the right side of the nose near the inner angle of the eye, breaking the bone into minute fragments. One of the fragments, apparently a portion of the right nasal bone, was picked out by the physician who first saw him. A female silver catheter passed up the right nostril showed its rounded end at the neighborhood of the internal angle of the eye, quite free from covering of bone

or other tissue. It raised in its passage the mass of bone fragments which immediately dropped back into the nostril when the catheter was removed. A long hare lip pin was passed beneath the lowest adherent fragments into the nostril, then the head being slowly depressed, the point was guided forward and upward, passing over the point where the right nasal bone was missing and made to emerge well beneath the left eyebrow. A bit of rubber was slipped over the head and point of the pin. The pin was left in place for six days and then withdrawn; and although the wound healed by granulation, the deformity is remarkably slight. The open hole is firmly closed, no air passing; the bones remain in *good line*."

CASE FIFTH.—Dr. Conway, house surgeon, City Hospital, Brooklyn, reports the two following cases: Mrs. —, aged 40, suffering from tertiary syphilis, was kicked by her husband and sustained a compound comminuted and depressed fracture of nasal bones. She was operated on by this method, the bones being elevated by ordinary dressing forceps and evaporating lotions applied. The needle was removed on the sixth day without difficulty, and the result was very satisfactory.

CASE SIXTH.—Mrs. —, aged 37, received a blow from her son's fist, fracturing the nasal bones. Displacement was not marked; operated as in previous case, and removed the needle at end of five days when the result was *perfect*.

Improvement of Sayre's Treatment for Spinal Curvature.

Mr. RICHARD DAVY, of London, places the patient in a hammock, face downward, arms hanging through slits in the canvas. Extension may then be

used or not, according to the views of the surgeon, and the plaster-of-Paris or other dressing leisurely applied, including the canvas. A free circulation of air is allowed access to the body, and the dressing dries rapidly, the patient often sleeping during the time employed. After the drying is complete the spare canvas is trimmed, and the patient literally takes up his bed and walks. Aside from the small expense and inconvenience involved, he thinks suspension not always safe in spinal, and especially cervical, caries. —*American Practitioner*.—*Canada Med. Record*.

Trephining a Lunatic, with Recovery.

(*Jour. of Ment. Sc.*, Jan., 1881.)

M. BACON.

A man, aet. 36, was struck on the head with a hammer. From that time on he lost the power of concentrating his attention, and finally became insane. The left pupil was dilated and a sunken cicatrix was found over the left parietal bone. Fifteen months after the injury trephining was performed. The bone was not found to be broken, but nevertheless a disc $\frac{3}{4}$ of an inch in diameter was removed. The wound healed rapidly under the antiseptic bandage. Soon after the operation the patient improved and in three months was discharged cured.—*Pac. Med. and Surg. Journal*.

Treatment of Intra-Capsular Fractures of the Femur.

Apply extension in two directions in opposition to two forces, longitudinally and laterally. Put adhesive strips along the leg and foot to hold a cord passing over pulley and attached to weight. Lateral extension is made by a five inch muslin band around the body. A splint is applied to the inner aspect of the thigh. A pulley is placed

opposite the crest of the ilium and four inches above it. Counter-extension is made by the body; the bed is elevated at the foot, one foot on the fractured side and eight inches on the other. The head post on the injured side is elevated four and a quarter inches. By this method the fragments are brought as nearly into apposition as is possible. The inner surface of the capsular ligament is rendered tense and applies itself to the sides of the neck and holds it.

It takes 14 lbs. to accomplish extension, and for lateral extension 8 to 9 lbs. When the irritation of muscles has subsided the weights may be diminished to 1½ lbs. or less.

The advantages of this method are: that it allows of the use of a bed pan; the danger from bed-sores is *nil*; the pain in the hip subsides, in a few days. —*St. Louis Med. and Surg. Record*.

On some of the Abuses of the Jacket Treatment of Spinal Disease.

BY WALTER PYE, F.R.S.

The writer, while acknowledging fully the debt European surgery owes to Dr. Sayre for the able advocacy of his treatment, and granting that it is due to his exertions that in England it has come into such general use, considers that in many cases the jacket is hastily and needlessly applied, and that its employment is often actively harmful.

He divides the cases in which the jacket treatment is abused into two classes:

A.—Those due to a wrong selection of cases.

B.—Those due to wrong methods of application of the jacket.

In class A the following are given as improper instances:

1. *Simple Ricketty Spines*, often mistaken for cases of commencing caries.

2. *Cases of Simple Lateral Curvature*,

in which the disease is perpetuated by the use of rigid support.

3. *Certain Cases of True Spinal Caries.* In infants, during the early progress of the disease, the older plan of rest and horizontal position succeeds better than does any attempt to immobilize the spinal column, and is free from the risk of preventing due development of the trunk; but the jacket may be used from the first in older children, with or without confinement to bed.

4. Cases in which the lungs or heart are affected, in addition to the affection of the spine.

5. Cases in which the carious spine is associated with any high degree of paralysis, incontinence of urine, etc.

In class B the following are the chief instances of misapplication of jackets:—

1. *Undue Heaviness*, many jackets, being far too thick and strong.

2. *Use of the Swing.*—This apparatus is considered to be, for children, useless, if not harmful, the object of extension being to allow the body to hang as straight as it may, while avoiding all risks of disturbing any adhesions between consolidating vertebræ, and to bring the chest-walls into a condition of extreme inspiration. It is held that these objects are best attained by holding the child by the arms, with the feet on the floor, or by the use of an inclined plane.

3. *Bad Fitting and Bad Shaping of the Jacket.*—More especially neglect of the inspiratory position of chest-walls, insufficient hold of the jacket on the pelvis, and inaccurate fitting to the spinal curve or angle.—*Amer. Jour. of Obstetrics.*

Abdominal Tumor Formed by Movable Spleen.

PROF. ROBERTS BARTHOLOW reports in the *College and Clinical Record*, Vol. II., No. 2, the following case: Mrs. M., aged 48, anæmic, but fairly nourished,

has an abdominal tumor lying principally in epigastric region, firm, somewhat movable and slightly elastic; can be grasped between thumb and finger over the navel; has firm and regular margin; is smooth; is differentiated from aneurism of aorta by being non-pulsating. Pelvic organs are excluded by its position being so high up. Tumor of liver excluded by there being an interval between the liver and the growth where there is *clear percussion note*. Stomach is not diseased because of no disturbance of its functions. Percussion over splenic region gives on left side perfectly clear note over whole area.

We have discovered then, either that the spleen does not occupy its usual position, or that it is very small. From the firmness, size, shape, and location of the tumor, I conclude that it is a movable spleen pushed over from its usual position.

The chances are that this spleen had undergone the changes characteristic of splenitis, before occupying this position in the epigastrium.

How may we relieve the patient? Two remedies, in particular, are of service for this purpose, ergotine and quinine. We will order hypodermic injection of ergotine (grs. iij., water, q. s.) over the region of the tumor three times a week, and the regular administration of quinine (gr. iij.) and ergotine (gr. j.) three times a day. In addition, we will direct the ointment of the red iodide of mercury, of which a small quantity is to be rubbed in at night. In India it has been found if the ointment is rubbed in while the rays of the sun are falling upon the spot, that it will have more effect.

The biniodide of mercury produces decided inflammation of the skin. We, therefore, direct that she use it until a decided effect is produced or desquamation occurs. She will continue this treatment for several weeks.

Cure of Goitre by Fluoric Acid.

Dr. EDWARD WOAKES gives, in the *Lancet*, a detailed account of a number of cases of goitre cured by fluoric acid internally. He begins treatment with fifteen minims of a one-half-per-cent. dilution of the acid three times a day, and, if necessary, increases the dose to twenty, thirty, forty, or even seventy minims and extends the time to several months. In a few it was conjoined with injections of tinct. iodine. Very few failed to be reasonably benefitted, and in eighty-five per cent. the cure was decided.—*Med. News.*—*South Med. Record.*

Tumor of the Cerebral Motor Zone.

Mrs. W., aged 30, was afflicted with headache from the autumn of 1879. In March, 1880, she had an attack of numbness in the left hand, followed by convulsions in the left arm, succeeded by general convulsions, most violent on the left side. After the attack the left upper extremity was weaker than the right. A number of similar attacks succeeded. More or less headache continued, accompanied by vomiting. The pain was the severest in the fronto-parietal region, and percussion around the right ear caused intense pain. Sight became imperfect, and double optic neuritis developed. Hearing became defective in the right ear; slight anæsthesia on the left side ensued, with paresis of the left side of the body and face. The left tendon reflex was diminished. The bowels and bladder were partially paralyzed. No sugar or albumen was present in the urine. The patient died on Aug. 27, 1880. At the post-mortem a tumor $1\frac{1}{2}$ inch in diameter was found, situated in the middle of the ascending parietal convolution, and the upper part of the inferior parietal lobule. The post-mortem completely confirmed the

diagnosis that had been made during life.—*Archives of Medicine.*

A Case of Bursal Swelling of the Wrist Successfully Treated by Division of the Annular Ligament.

Dr. J. E. COPELAND has reported a case of bursal swelling of the wrist (*American Journal of Medical Sciences*, July, 1881), in which relief was obtained by resorting to Syme's operation of cutting through the annular ligament. The patient had been heroically treated by a number of practitioners by incisions, punctures, blisters, etc., and all without benefit. The affected wrist measured thirteen and one-fourth inches in circumference, the corresponding wrist of the normal size measured seven and three-fourths inches. There were two firm and hard protuberances over the styloid processes, both of the radius and the ulnar. On manipulating the parts between these protuberances, a sensation as of hard movable bodies impacted in fluid was imparted to the fingers. The operation consisted of dividing the annular ligament by an incision between the tendons of the extensor communis digitorum and the extensor carpi ulnaris muscles. Imbedded in the substance of the enlarged wrist, along the incision, were a number of fibrous or cartilaginous bodies of different sizes, ranging from that of a flax-seed to a small cherry-stone, and of irregular shapes. After the operation the patient was relieved of pain. The wound, treated antiseptically, was kept open and treated upon general principles, until the end of the sixth week after the operation; when the wrist was reduced to eight and one-fourth inches in circumference. Dr. Copeland is inclined to the opinion that operative measures are justifiable in swellings of this character, which strengthens the theory already advanced by Syme.—*Med. Rec.*, Vol. xx., No. 16.

A Case of Rupture of the Intestines.

The patient, a young man of nineteen, had been drinking, and while in a stupid condition he fell off the shaft of a cart he was driving, and the wheel passed over his abdomen. He showed no notable outward bruise, and was quite comfortable until the next afternoon, when he was taken with symptoms of peritonitis, and soon died. The autopsy showed the duodenum to be cut entirely across.—*Med. Record.*

Rupture of the Bladder, with Recovery.

In August, 1880, Mrs. T., of Oakdale, was stepping upon the steps at the entrance of a neighbor's house, when she lost her balance, and fell back, striking the ground on her hip, a distance of about two feet. Soon she began to feel a sickening sensation, and distress in the lower part of the bowels and back. She kept around, however, sufficiently to prepare supper for her husband, but could eat nothing herself. She passed a restless and painful night. The next morning she sent for her physician, Dr. Osler. He recognized some severe internal injury, but could not determine the extent. She had not passed water since the accident, although she had the desire to do so. The doctor introduced the catheter and drew off over an ounce of urine. During the day there was vomiting several times, and toward evening subsultus, thirst, with increasing tenderness and she was evidently growing worse. Thirty hours after the injury I saw the patient with Dr. Osler. Found the pulse 120, skin inclined to moisture, anxious countenance, and hic-cough. There was tenderness and considerable fulness in the region of the bladder, but no extended tympanitis. The catheter was again introduced but it drew only a few drops of urine. The bladder was completely flattened over the

swelling or tumor beneath. The uterus was explored and found of normal size, but moved to the right side. By this time we were satisfied there was rupture of the bladder, and we informed the husband of the almost certain fatality. Further vaginal examination revealed a tumor posterior to the os uteri, having a distinct fluctuation. Into this an exploring needle was inserted, which settled the diagnosis. A larger incision was made by which about two pints of sero-purulent urine escaped. Manifest relief soon followed. The next day the graver symptoms had subsided, and the case appeared more hopeful.

After this time she remained under the assiduous care of Dr. Osler, who treated her with carbolic acid wash, the frequent use of the catheter as a drainage tube, and opium and quinine internally. She recovered in eight weeks, having had one slight relapse of fever during the time.

Mrs. T. was about 40 years old, light complexion, and inclined to be fleshy, and has had several children. As there were but few symptoms of peritonitis, it is fair to conclude that the rupture in the bladder was chiefly or wholly outside of the peritoneum, which let the urine escape into the pelvic connective tissue.

Of over fifty cases of this injury mentioned in Holmes' System of Surgery, all were fatal but three. Of the three which recovered there was only one in which the rupture and urine extended within the peritoneum.—A. T. HUDSON, M. D., *Stockton, Cal.*

Incision of the Pericardium.

Prof. S. ROSENSTEIN (Leiden) on Jan. 16th examined a boy ten years old. Two weeks before he was taken sick with fever and with gastric symptoms, and since that time he had been short

of breath and had a little cough. Careful examination revealed the presence of a very considerable pericardial exudation. Change from lying to sitting made no change in the form or extent of the area of dulness. The boy had no fever, the skin of the thorax was not œdematous. An exploratory puncture with a hypodermic syringe showed pus. The increase of the dyspnœa led ROSENSTEIN to perform puncture with aspiration, by means of which 620 ccm. of purely purulent fluid were withdrawn, with the result of immediate and complete euphoria. But on the very next day the pericardial exudation increased, and a left pleuritis developed, so that two days later 1,200 ccm. of pleuritic and, again, 120 ccm. of pericardial exudation were removed with the aspirator. The general condition of the patient now growing worse, it was decided, on the eleventh day after admission, to incise the pericardium under antiseptic precautions. This was done, two drains were introduced, and Lister's bandage applied. A magical improvement of the general condition began. Nineteen days after the incision the boy was well, so far as the pericardium was concerned. The pleuritis having meantime become purulent, an incision of the pleura was necessary, but this also healed completely after some weeks. ROSENSTEIN remarks that the case teaches, 1. That purulent pericarditis, like empyema, may run its course without any fever or any œdema of the skin, so that it can only be recognized by exploratory puncture. 2. The fear of myocarditic changes should not hold us back from removing the exudation in suitable cases, because all the symptoms which make such probable can be explained by functional changes in the elasticity and contractility of the heart-muscles. 3. When there is a large collection of

fluid in the pericardium, change of the patient's position may have no influence on the height of the area of dulness, so that this criterion cannot be relied upon in differentiating from dilatation of the heart.—*Am. Jour. of Obstetrics*, Vol. 14, No. 4.

Treatment of Hydrocele by Injections of Chloride of Zinc.

Impressed by the favorable results obtained in the treatment of sebaceous cysts with injections of chloride of zinc, Borck employed this procedure in a case of hydrocele of the spermatic cord, which he had previously tapped several times without permanent benefit. A few drops of a five per cent. solution were injected by means of a hypodermic syringe. This caused slight smarting, which lasted but a few minutes. The patient was kept in bed during the succeeding twenty-four hours. For a few days there was moderate sensitiveness on pressure over the hydrocele, but both swelling and pain rapidly subsided, and by the twelfth day the tumor had entirely disappeared, leaving only a slight thickening of the spermatic cord at the site of the injection. Even of this no trace was left after the lapse of about five weeks.—*Centralblatt für Chirurgie*, July 23, 1881.

Arnica in Furunculosis.

DR. PLANAT (*Revue de Thérapeutique Médico-Chirurgicale*) claims very good results from the use of arnica paste in the treatment of furuncles of a purely inflammatory character. Arnica, according to him, aborts furuncles with great promptitude, probably by reason of its action on the vaso-constrictor nerves of the superficial vessels of the skin. The inunctions are made with the following mixture: Extract of fresh flowers of arnica, two drachms and a half; honey, five drachms. If this mix-

ture prove to be too liquid, a small quantity of lycopodium should be added to it to render it sufficiently adhesive. This paste is spread in moderate thickness on waxed linen or on diachylon plaster and applied to the furuncle. The dressing should be renewed every twenty-four hours. Two or three applications generally suffice to abort furuncles. Occasionally, when due to diathetic conditions, internal treatment will be rendered somewhat necessary.—*Chicago Med. Review.*

Septicæmia resulting from a Leech-Bite.

The *Gazz. Med. Ital.* quotes the following case: A Bernese had been suffering from toothache for several days, and to relieve it he followed out the advice of a dentist by applying a leech to the gum. Two hours later the pain increased, and the lip became the seat of an inflammation which extended to the cheek, neck, and breast. The following day the head was swollen, respiration was difficult, and the patient was in high fever. A few hours later he was attacked with delirium, tremor, and convulsive vomiting. He died during the night of the second day, from septicæmia, as demonstrated by the autopsy. The leech-bite was larger than the ordinary and its borders were black and gangrenous. A poison of unknown nature had evidently gained access to the system through this wound.

Lister's Antiseptic Treatment in Surgical Wounds.

Dr. Boeckel (*Gaz. Med. de Strasbourg*, December 1, 1880) gives a table of statistics of major amputations performed by himself, some with and some without antiseptic precautions. Fifteen amputations of the thigh were performed antiseptically with four deaths, and seven were treated otherwise with three deaths;

eighteen amputations of the leg were treated antiseptically without a death, and nineteen treated in other ways with four deaths. In going into the causes of death, the author concludes that in neither case can the deaths be attributed to the method of dressing employed. Nevertheless he thinks that the advantage is decidedly with the cases treated antiseptically, on account of the rapid healing, the absence of fever and of suppuration, and the rarity of the dressings in these cases. He mentions the occurrence of septic fever in a few cases, and with Edleberg, he attributes this to absorption of blood from the wound.—*London Med. Record.*

A Novel Treatment of Synovitis.

H. A. Martin, M. D., Boston, says: "enlargement of joints, from whatever cause arising," can be cured by evacuation of the sac by aspiration, and the subsequent wearing of the pure India-rubber bandage which he had introduced for the treatment of ulcers of the leg. He had treated hundreds of cases by these means and he had no hesitation in saying that it was the only treatment which ought to be adopted in cases of synovitis.

DIGESTIVE TRACT.

On the Cause and Treatment of Hemorrhoids.

In an article published in the *St. Louis Courier of Medicine*, for September, 1881, Dr. S. S. Todd, of Kansas City, observes:—

Constipation of the bowels is the almost constant predisposing, as the use of drastic cathartics is commonly the exciting cause of the disease, and no treatment can be successful that does not embrace within its scope an assurance

of one daily easy evacuation of the *lower bowel*.

The first step in the treatment of *recent* cases should be the administration of a saline cathartic, and the best is sulphate of magnesia. After this, the following pill may be used: compound extract colocynth, grs. xxx.; extract nuxvomica, grs. xx.; extract belladonna, grs. x. Divide into 40 pills. One to be taken every evening on going to bed.

The patient should also have a fixed hour at which to go to stool, and steadfastly restrain any desire for this at other times.

Should the pill above mentioned cause a liquid stool, or should it cause more than one stool, your object will be defeated if you persist, and the quantity of compound extract of colocynth must be diminished. On the other hand, should it fail to secure one soft and consistent motion daily, the quantity of colocynth must be cautiously increased.

In addition to the above, the following will be found to give instant relief from pain, and accelerate the cure: iodoform, 3j; balsam Peru, 3ij; cocoa butter and white wax, of each, 3iss; calcined magnesia, 3j. Incorporate the mass *thoroughly*, and divide into twelve suppositories. Insert one after each evacuation of the bowels, and oftener, if needed.

Old and chronic cases he treats as follows: All tumors found at the verge of the anus, and covered in part or wholly with integument, are clipped off with the scissors. If situated within the external sphincter, the bowels having been moved with a dose of sulphate of magnesia given a few hours before, the patient is placed over a vessel, and directed to strain (a vessel filled with hot water is best). If the tumors do not come within reach in this way, the finger should be thrust into the bowel, provoking tenes-

mus, and the patient again be instructed to force the piles down. When within reach, the nates being separated by an assistant, the tumors are seized one by one with forceps, and held, while, with the hypodermic syringe, from five to ten minims of a solution of nitrate of silver, one drachm to the ounce of distilled water, are injected into each, not stopping till all have been thus injected. No pain is felt except what is caused by handling parts rendered hyper-sensitive by protracted irritation.

One of the suppositories before mentioned may now be passed into the bowel, and thenceforth, if the treatment already given for removal of constipation be followed up assiduously and patiently little further inconvenience will be felt and no further treatment required. Even though the suppository be omitted, little pain is felt, and the patient goes at once about his business. The tumors immediately become hard, atrophy, and in about ten days have wholly disappeared.—*Med. and Surg. Reporter*.

Aloes for Piles.

Dr. FORDYCE BARKER advocates the use of aloes in hemorrhoids. The following formula is proposed by him: R. Pulv. aloes. sqc., saponis castil, āā ʒj.; ext. hyoscyami, 3 ss.; pulv. ipecac, grs. v. M. ft. pil. No. xx. Sig.—One morning and evening.

When the patient is anæmic he adds to the above twenty grains of the sulphate of iron. A popular and very useful aperient in piles is a combination of equal parts of the bitartrate of potassium and sulphur, given in milk. Sulphur internally exercises a most soothing influence on the inflamed tumors more than can be fairly attributable to its aperient action.

In those who have, or are predisposed

to have hemorrhoids, Dr. Barker recommends the following: *R.* Magnesiae sulph., magnesia carb., potass., bitart. sulphur. sublim., aa \bar{z} ss. *M.* Sig.—From a teaspoonful to tablespoonful of the powder in a wineglass of sugar and water before breakfast.

Prolapsus Ani.

R. EICHLER, M.D., in *Western Lancet*, says: A boy five years of age came under my treatment, suffering from prolapsus ani of two years standing. The gut came out to the extent of two and a half inches after each passage. My treatment at first was of a routine kind—cold effusions, cauterizations with nitrate of silver, tincture of iron, etc. The bowel persisted in coming down at every passage. As a last resort, I tried an ergotine suppository. *R.* Ergotine, gr. ij.; but. cocoa, q. s. *M.* ft. suppos., No. i. One after each passage.

The effect of the remedy has been magical, as after the use of a few of the suppositories, there has been no return of the condition, and the case is cured.—*Canada Lancet.*

VENERIAL DISEASES.

Contribution to the Study of Inherited Syphilis in Children.

Dr. H. A. READ concludes his article in the "Proceedings of the Med. Soc. of Kings Co.," for November, as follows:

Treatment.—In this department alone has much advancement been made. I have abandoned the inunction plan and all internal administration of any kind, except the bichloride. I give a mixture containing half a grain of the drug in three ounces of water, with a little syrup, and of this give half a teaspoonful every hour or two, to begin with. By this treatment we avoid the dirtiness

and greasiness and trouble of the inunction plan—and the time and trouble are no small items with laboring people—and we also shun the disagreeable effects often following the administration of small doses of calomel. Since my first adoption of the bichloride treatment, over four years ago, I have never seen a bad result from its use. My plan is to give it until all traces of the disease have disappeared, and then to give it in "tonic" doses for a month or six weeks longer. The dose is a ninety-sixth of a grain, and giving it in "tonic" doses is only giving it thrice daily, instead of every hour, as at first.

New Treatment of Syphilis.

M. MARTINEAU has published the result of a large number of cases of syphilis treated by a new method at the Hospital Lourcine. The preparation employed consists of a mixture of powdered peptone, chloride of ammonium, and bichloride of mercury, which are dissolved in water and glycerine. In order to have a standard solution which shall contain five centigrams (.02 grain) in a gram, the following proportions are taken:

R. Powdered peptone (Catillon), grs. ix.; chloride of ammonium, grs. ix.; bichloride of mercury, grs. vj. *M.*

These are dissolved in glycerine, seventy-two grams; water, twenty-four grams. This solution, which the author calls "normal," further diluted with five parts of distilled water, is of such strength that an ordinary French hypodermic syringe represents ten milligrams, or one-fifth of a grain of corrosive sublimate. The solution is injected subcutaneously, and the dose employed by M. MARTINEAU has varied from two milligrams ($\frac{1}{50}$ grain) to ten ($\frac{1}{10}$ grain) of bichloride of mercury. Altogether one hundred and seventy-two patients have

been under observation, and a total number of three thousand eight hundred and thirty-eight hypodermic injections made. No abscesses or sloughs have ever followed the operation; sometimes a defective injection has given rise to a lump, but this has always rapidly disappeared. There is never either stomatitis or salivation, even with one-fifth of a grain of the mercuric salt daily.

Venereal Warts.

By applying twice daily, equal parts of powdered alum (burnt) and tannin to those troublesome growths, they can be removed in three or four days.—*Canada Med. Record.*

Iodide of Sodium in Syphilis.

Dr. GOULEY has for ten years been using the iodide of sodium instead of the iodide of potassium, believing that it was the potassium, and not the iodine, which was the toxic agent. He has found that large doses of iodide of sodium were much better borne than were equally large doses of iodide of potassium; and besides, the sodic salts in the same quantity had no tendency to produce sclerosis of the kidneys. He condemns the excessively large doses of iodide of potassium so frequently given, and believes that the physician who gives an ounce of the drug daily, and continues it for weeks and months, is guilty of malpractice. The syphilis may be cured, but the patient very likely would be killed by the chronic interstitial nephritis developed by this excessive and prolonged administration of the iodide of potassium.

As is well known, there are patients who cannot tolerate the minutest doses of iodide of potassium, while there are others who require very large doses. In his belief the latter are more likely to be harmed by the drug, for their stom-

achs tolerate the large doses, but in the end their kidneys suffer. He has had patients who could not bear a single grain at a dose, and others who required very large doses, but the latter have always given him great anxiety. He has known a most violent hæmaturia to follow the use of forty grains of the iodide of potassium three times a day, and continued for two weeks. The symptom disappeared within a few days after discontinuing the drug, and afterward he was careful to give smaller doses.—*Med. Record.*

The Treatment of Syphilis by Subcutaneous Injection.

Dr. N. B. SIZER, Brooklyn "*Annals of Anatomy and Surgery*," for Oct., 1881, says:

Scarenzio, of Pavia, was the first to employ this method, about 1854, using calomel suspended in glycerine (*Annales Universelles de Medicine*, 1864). His formula was: Calomel, 0 gr. 20 ctgr. to 0 gr. 30 ctgr.; glycerine (or mucilage, or water), 1 gramme. M.—For one dose.

One or two such injections caused the lesions to disappear, after eight to fifteen days.

In Great Britain, Berkeley-Hill seems to have used, about 1866, injections of the corrosive chloride in eleven cases of syphilis, with a dose of one milligramme, and with good results. If the dose was increased, abscesses at point of puncture, salivation, colic and diarrhœa, were often found.

Lewen, at "La Charité," in Berlin, experimented in 1868 on a grand scale, using the corrosive chloride dissolved in water at a dosage of 5 to 10 milligrammes, adding morphia in some cases to make the injection less painful. His average number of injections was sixteen for each patient, and the average

total quantity of the sublimate was 15 centigrammes for each. Results good.

Liégeois communicated his results to the Paris "Society of Surgery," at its meetings held on June 2d and 9th, 1869. His formula was as follows: Distilled water, 90 grammes; sublimate, 0.20 ctgrms.; hydrochlorate of Morphia, 0.10 ctgrms. M.—To inject 1 gramme.

Each patient had two injections every day. Average length of treatment, thirty-seven days, and relapses were noticed in 37½ per cent. He thought that the drug cured much more rapidly than if administered by way of the mouth.

Aimé-Martin presented his method to the "Society of Medicine," of Paris, on the 7th of August, 1868. He prefers a formula like the following: Double iodide of mercury and potassium, 0.40 centigrammes; muriat. of morphia 0.05 centigrammes; distilled water, 10 grammes. M.—Inject 10 drops every other day.

The morphia to be added at moment of injection, to avoid precipitation. Martin reports his cures as rapid and free from local lesions.

Bricheteau (*Bulletin de Thérapeutique*, 1869) uses this formula: Double iodide of mercury and sodium, 1 gr. 50 centigrammes; distilled water, 100 grammes. M.—5 to 10 drops as an injection, once or twice a day.

One gramme contains one centigramme of the mercuric salt. Belhomme employs this formula: Double iodide of mercury and morphia, 0 gr. 50 centigrammes; distilled water, 20 grammes. M.—5 to 10 drops once a day.

Bouchardat mentions (1872) the following solution (of Staub): Corrosive chloride, 1 gr. 25 centig.; ammonium chloride, 1 gr. 25 centig.; sodium chloride, 1 gr. 15 centig.; white of egg, No. 1; distilled water, 250 grammes. M.

This is a great advance, and the mix-

ture is called "Solution of the Chloro-Albuminate of Mercury," by its inventor.

Bamberger used chemically pure peptone in combination with mercury.

Catillon ("*Repertoire de Pharmacie*" quoted in "*Druggists' Circular*," January, 1881) uses this formula: Lean beef, minced, 2 pounds; hydrochloric acid (sp. gr. 1.18), 5 drachms; water, 10 pints; pepsine, sufficient.

Digest 12 hours at 45 deg. C. with slight excess of pepsine. Keep temperature between 43 deg. C. and 48 deg. C.; agitate from time to time, and after two to six hours the mixture is nearly transparent. After 12 hours strain and filter. Saturate with bi-carbonate of soda, and evaporate on water-bath till a pellicle forms on its surface. It then has, when cold, a sp. gr. of 1.15, and contains one-half of its weight of solid peptones.

Bamberger's formula was this: Having made a solution of the sublimate in water of 5 per cent., and one of chloride of sodium of 20 per cent., he dissolved 1 gramme of "meat peptone" in 50 cubic centimetres of distilled water, and filtered it. He then adds to this last 20 cubic centimetres of the mercury solution, and after well mixing he adds just enough of the sodium chloride solution to dissolve the precipitate of peptonate of mercury, the amount required being about 15 to 16 cubic centimetres. Then add to the solution of "mercuric peptone" enough distilled water to make up 100 cubic centimetres, thus making it just one per cent. mercury—that is, 1 gramme of the solution represents 1 centigramme of the sublimate, about one-sixth of a grain. The solution is fit for use after settling some days, decantation and filtration. The dose is 1 cubic centimetre every three or four days; if oftener repeated, abscesses and salivation are to be feared.

Terrillon used this formula during his earlier experiments. Later on he used the following formula: Biniodide of mercury, 1 gramme; potassium iodide, 1 gramme; tribasic sodic phosphate, 2 grammes; distilled water, up to 50 cubic centimetres.

Martineau, of the "Hospital de Lourcine," has, since the 12th April last, used the following formula: Bichloride of mercury, 10 grammes; peptone de catillon, dry, chloride of ammonia, C. P. of each, 15 grammes. 1 gramme contains 25 centigrammes of the sublimate. This formula has given best results.

The following solutions have proved excellent:

Solution (A).

Ammoniated mercuric peptone, 0 gr. 40 centig.; distilled water, 30 grammes.

M. This contains 4 milligrammes of sublimate in 1 gr. 20 centig., and will keep well for several days.

Solution (B) is more stable.

Mercuric peptone (as above), 0 gr. 40 centig.; distilled water, 25 grammes; neutral glycerine, 6 grammes.

M. Dose and strength same as (A).

Solution (C) appears entirely stable.

Mercuric peptone, 0 gr. 40 centig.; glycerine, C. P., 36 grammes.

M. Same dose and strength as (A) and (B).

Is There a Specific Urethritis?

Dr. P. ALBERT MORROW (*New York Medical Journal and Obstetrical Review*.) handles the question of the specific or non-specific nature of gonorrhœa. He concludes that the position of the *virulists* rest altogether upon pure hypothesis, and is wholly untenable, while all the facts—experimental, clinical and pathological—are overwhelmingly in favor of the non-specific character of gonorrhœal inflammation. When we apply the gauge of specificity to gonorrhœa it cor-

responds to none of the conditions of an undoubtedly specific inflammation. No artificial production of any disease belonging to this group is possible; a specific disease is the product alone of a specific poison. Gonorrhœa, on the contrary, may be due to a variety of causes—contagious, irritant [mechanical or chemical], diathetic, etc. Again, in all specific diseases there is between the time of infection and the first expression of the disease a period of incubation. No incubation, properly so called, characterizes gonorrhœa. A drop of this same gonorrhœal pus, which may require two or three days to excite suppuration of the urethra, will develop such effect in a few hours when applied to the conjunctiva, showing that the so-called incubation depends not upon the quality of the exciting cause, but upon the susceptibility of the mucous membrane. Another distinctive peculiarity of this group is that a single attack of the disease confers almost complete security from another attack—a peculiarity precisely the opposite of what is observed of gonorrhœa. The morbid poison of a specific inflammation, once in action, continues until the textural predisposition to its special stimulus is exhausted. The patient is incapable of regenerating the poison or of being affected by it when exposed anew. Both of these conditions are negated in the clinical history of gonorrhœa. Finally, specific inflammation determines special pathological changes, and demands special treatment. Identical pathological processes are met with in urethritis from various causes, and the most radical of virulists treat all urethral inflammations alike.—*St. Louis Med. and Surg. Record*.

Pyrogallic Acid in Chancroids.

In the *New York Medical Journal* we find a synopsis of a paper on this sub-

ject, contributed by Lermoyez and Hitier to the *Bulletin Générale de Thérapeutique*. The pyrogallic acid was employed in the form of a vaseline ointment, of the strength of one to five. Starch is added to the mixture to stiffen it, and prevents its liquefying after it is applied to the body. The formula is as follows: Starch, 40 parts; vaseline, 120 parts; pyrogallic acid, 40 parts. Care should be taken to have the ointment fresh. On exposure to the air it soon became brown and lost its strength. It was found equally applicable to all forms of chancre and in all situations. It was only slightly painful, though it had a mild caustic effect when first applied. This caustic action soon disappeared. The pain produced, it is claimed, was not greater than would be caused by the contact of any indifferent body with so sensitive a sore. Under its influence the chancres, even when phagedenic, healed with surprising rapidity.

Gonorrhœa.

The sulpho-carbolate of zinc has been extolled by Dr. W. T. PARKER, of Mass., as an injection in gonorrhœa.

R. Zinci sulpho-carbolatis., ʒj.; mucilag. acac., ʒj.; extract opii aquosi, ʒj.; aquæ, ʒvj. M. Use as injection, night and morning.

Hydrastis still finds advocates. Bartholow recommends a drachm of hydrastia (the alkaloid) to four ounces of mucilage of acacia, and has found no injection so uniformly successful. Phillips prefers an injection made by adding one or two drachms of the tincture to a pint of water, and of this orders a syringeful to be injected up the urethra every half hour for seven or eight hours for two or three days.—*Med. and Surg. Reporter*.

MISCELLANEOUS.

The Causes of Failure in Obtaining Union in Operation Wounds, and on the Methods Best Calculated to Secure It.

PROF. WM. WARREN GREEN, Int. Med. Cong., said, that wounds were more certain to heal by first intention, if thoroughly excluded *from the air*, and preferred fine cotton wool to all other agents; it is light, elastic and *air tight* and if the *germ theory* is assumed, Pasteur has proved that cotton wool is a *perfect filter* for all germs and spores. *Thorough drainage* is an important element.

For this purpose I prefer hair-drains whenever applicable, as in small or superficial cavities, as after removal of tumors, excision of the mamma, and in amputations. I speak, of course, of *primary drainage*—for the removal of the bloody serum that flows directly after the wound is closed. After intra-peritoneal operations, when needed, I prefer glass or decalcified bone.

Whatever is used for cleansing the parts during any important operation, whether by sponging or irrigation, should be of the same temperature, or a little higher, than that of the body.

To control hemorrhage *animal* ligatures should be used, rendered antiseptic. As to Listerism I most positively object to *carbolic acid* owing to cases of poisoning which I have observed, especially as it relates to exciting disease of the *kidneys*. Carbolic acid is not a *germicide*, it does not destroy bacteria, it paralyzes or anæsthetizes them *while applied* and when the fumes pass off they recover and become as lively as ever. In private practice I prefer and use a saturated solution of *boracic acid* which is antiseptic and germicidal.

One thing, however, must be said for

carbolic acid. It is a prophylactic against inflammation, and a useful remedy in certain painful inflammatory and ulcerative processes. But it is too energetic for application to raw surfaces.

In conclusion, let me say, that so far as the local management of wounds best calculated to secure union by first intention is concerned, I at present prefer the plan I have indicated.

I have not alluded to, but we must never forget, the all-important matters of the patient's surroundings, and of constitutional conditions and treatment.

1. The greatest possible cleanliness in every respect from first to last.

2. The use of aseptic animal ligatures in sufficient numbers to control all hemorrhage.

3. Thorough drainage, used with discrimination as to different methods in different cases, and as to time of retention of drain.

4. The maintenance of the normal temperature of the parts during the operation. For which purpose use warm water—better to have been boiled—with some such article in solution of germicidal strength, as chlorine, boracic acid, salicylic acid, etc.

5. Accurate, firm apposition by a *sufficient number* of sutures of some non-irritating material, such as hair, perfectly waxed silk, or metallic thread.

6th and finally.—The perfect covering of the parts with light compresses of pure cotton-wool supported by proper bandages. When there is to be much oozing, absorbent cotton should be applied next to the surface to take up the contents of the drains. Otherwise, nice wadding is sufficient.

Chronic Ulcers.

DR. L. A. DAVIDSON, of West Virginia, writes, that he cured an ulcer of 32 years' standing, by the application

of the following: *R.* Acidi tannici, \mathfrak{z} j.; glycerinæ, 3 iij.; ext. pic canad., 3 iv. M. To be applied on absorbent cotton.—*Med. and Surg. Reporter.*

Treatment of Ulcers of the Leg.

BY PROF. HAL. C. WYMAN, M. D.

Some surgeons advise section of the cutaneous nerve-trunks which communicate with the ulcer, and with that object in view make an incision through the integument completely encircling the ulcer.

Painful or irritable ulcers of the leg often heal quickly after such treatment. We can accomplish a cure by less severe means. We can relieve the pain and irritability by applying adhesive plasters to the limb in such a way that the edges of the ulcer will be, in a measure, approximated, and the granulations crowded over the exposed nerve endings so as to protect them from air and friction. To dress an ulcer in the way indicated you may cut strips an inch wide of the common surgeon's plaster (Diachylon), long enough to reach once and a half around the leg. Then elevate the leg so as to take off much of the blood pressure and apply the strips one after another from below upwards, in such a way that the ends will cross obliquely on the front of the leg and by pulling on the end the edges of the ulcer be made to approach. Apply simple cerate as a daily dressing to the raw surface, and roll snugly from ankle to knee a strong flannel bandage.

I have found flannel bandages three inches in width and ten feet long to answer better in these cases than the elastic rubber or old linen or cotton. They are sufficiently elastic to feel comfortable and are not unpleasantly warm.—*Mich. Med. News.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Remarks on Chronic Inflammation of the Knee-Joint, with Description of a new Apparatus.

Dr. SIMON A. FOSTER, of New York
(*Annals of Anatomy and Surgery*, Vol.
v. No. 1), says :

In chronic knee-joint inflammation, after the lesion has involved the osseous structure, we meet with a deformity due to the action of the contracted hamstring muscles, which, unless arrested, sooner or later terminates in subluxation of the tibia. The causes operating to produce this posterior displacement of the head of the tibia, are amply explained upon the basis of the continued reflex spasm of the flexors, which gradually draws the head of the tibia backward as in the normal act of flexion. It has been pointed out by Dr. Newton M. Shaffer, on many occasions, and I have seen many illustrations of the fact, that we do not find the peculiar reflex spasm of the muscles in chronic joint disease until an osteitis is developed ; or, in other words, that chronic synovitis, *per se*, is not accompanied by reflex disturbances, and subluxation or joint-rigidity is not among its characteristics. In my practice among the patients of the Orthopædic Dispensary, I have found many patients suffering from chronic osteitis of the knee, and as the Institution encourages the assistant staff in these studies, and permits a judicious latitude in the way of experiment, I was led to think especially of these cases, and to attempt to devise an instrument which would meet the indications and which

would be easily and readily adjusted. No one who has seen the admirable action of Dr. Shaffer's knee-splint* can doubt that it meets in every way the indications in chronic osteitis. It is, however, somewhat expensive, and some experience is needed to properly manipulate it.

The splint I have devised was suggested by this apparatus, and its essential principles are some of its features. I have often noted the great relief afforded by rest in chronic osteitis of the knee-joint. In dispensary practice I have used a simple retention splint with immediate, but as the sequel proved, temporary relief. There would occur, sooner or later, paroxysms of pain, indicating that there was some defect in the system of simple rest and immobilization. In a recent lecture upon this subject, Dr. Shaffer has distinctly pointed out that the ordinary forms of apparatus and those making a fulcrum of the diseased articular surfaces, produce a greater or less modification of mobility; but they do not remove inter-articular pressure, nor do they antagonize the reflex muscular action. In order to successfully meet all the indications, we must apply a direct pressure to the head of the tibia, not at its lower third as is usually done, and a direct traction should be applied after the head of the tibia has been either supported or slightly moved toward extension.

* Or: reflex Muscular Contraction and Atrophy in Joint Disease, with remarks on Mechanical Extension and a description of New Apparatus. By Newton M. Shaffer, M. D., *Archives of Clinical Surgery*, June, 1877.

Dr. Shaffer also rightly insists that in imitating the movement of the tibia, while passing from flexion to extension, we should have an independent movement of the apparatus at the knee-joint. In his apparatus he has introduced this very accurately, and it accomplishes all that is desired. In my own splint I have introduced a bar with a slat and screws, and an antero-posterior hinge, so that in

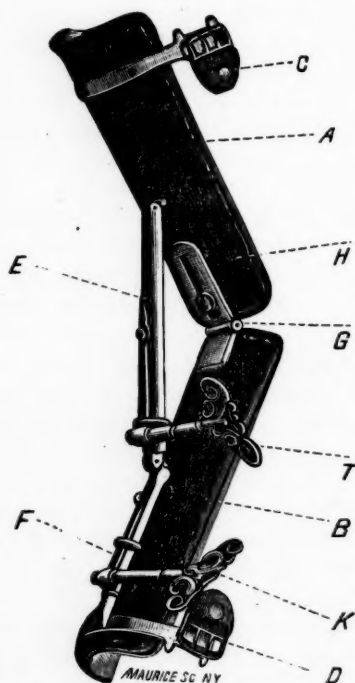


FIG. 1. Splint for the treatment of chronic inflammation of the knee-joint.

applying extension we can carry the head of the tibia toward extension and then apply traction in the acquired position, as in Dr. Shaffer's splint. The advantage claimed for this splint is that it is cheaper, more easily managed, and that, in the majority of instances, it meets all the indications.

The splint, in detail, is shown in Fig. 1. It consists of three essential parts—the thigh, the leg, and intermediate, the

thigh piece A is made of sheet steel padded, and is joined to the leg piece B by the hinged slot G, and the extension rod E is made to terminate *above the center of the leg-piece B*, so that as we apply an extension force—the slotted joint being free—it throws the whole leg piece forward at the expense of an independent movement at the hinged slot. The slotted joint is then fixed by turning the nut with a wrench. We therefore throw the whole tibia forward toward the position of extension, and in the acquired position we apply a direct traction by the traction rod F. All inter-articular pressure is thus removed, and we have an advantageous position without making, as do the ordinary forms of apparatus, a fulcrum of the diseased articular surfaces.

To properly adjust this instrument, we first apply adhesive plaster to the leg and thigh, after the Davis method.* We apply strips to either side of the leg and thigh, and attach webbing to the ends so that they may be properly secured to the buckles on the bands at either end of the splint. Over the plaster a bandage is applied. The apparatus is then fixed to the limb by the webbing straps and buckles and a few turns of bandage over the lower portion of the splint and leg; extension is then made until the head of the tibia is firmly supported, the joint is then made fast. The apparatus is now adjusted, as all apparatus should be, in the exact position of the deformity. The whole splint is now bandaged firmly to the leg, and finally true traction is exerted by the rod at F. The extension bar E can now be used gently, and the flexion reduced to a moderate degree. Never use force enough to give the patient any pain.

* Conservative Surgery. By H. G. Davis, M.D., page 233.

Fig. 2 shows the instrument applied. I have used this splint in five cases, and always with marked relief. Its application is simple, its cost is comparatively little, and it needs no special training to adjust it.

In taking the measurements for the instrument maker I use a piece of ordinary pasteboard cut long enough to cover two-thirds of the posterior portion



FIG. 2. Splint in place.

of the thigh, starting from the knee. The same pattern is taken of the leg. The pieces are then cut the proper width, which should not be so wide as to enclose the thigh or leg to any extent, but only sufficient to make a shallow trough in which the limb will rest comfortably; next I take the circumference of the thigh at its upper two-thirds, taking half of this measurement as the size of the band to which the buckles are attached. The same meas-

ure is taken for the band on the leg piece. The angle of flexion is then taken. This is not absolutely necessary, as the extension bar can be made short enough to allow the splint to be flexed to a right angle without interfering with its efficiency. The instrument may be used for either the right or left limb.

Amputation of both Legs. Fracture of the Femur—Recovery.

Dr. J. J. BUCHANAN (*Med. and Surg. Reporter*) reports the following:

Henry N., a brakeman, aged twenty-one, was struck by a moving car, and had fallen between the rails, the car passing over him and the wheels comminuting the bones of his left leg and right ankle, and pulpifying the surrounding soft parts. Besides these injuries, he had sustained a fracture of the left thigh bone in its upper third, and wounds of the face and scalp.

Twenty-five minutes after admission the patient was anesthetized with a mixture of equal parts of ether, chloroform and alcohol. Both legs were amputated. The Esmarch bandage was used in both instances. Anterior skin and posterior musculo-tegumentary flaps were formed and section of the bones of the left leg made in the middle third and of the right at the junction of the middle and lower thirds. The arteries were secured by torsion and the oozing checked by the application of towels wrung out of water as hot as could be borne by the hand. The edges of the flaps were accurately apposed by silver wire sutures and adhesive strips. No drainage tubes were used. The dressing was resin cerate and absorbent cotton. The patient was put to bed and the fractured thigh steadied by lateral sand bags, no extension being at first attempted.

During the first three days the pulse

was full and regular, and remained between 108 and 114 per minute. The temperature ranged between 99.5° and 101.6°. Liquid diet was used exclusively. The patient's appetite was fair. One-sixth grain morphinæ sulphat. was given hypodermically each evening, which secured sound sleep throughout the night. But little pain was experienced. At the end of the third day the dressings were for the first time removed, and both stumps were found in excellent condition. There was considerable suppuration, but no sloughing. Gentle pressure was used to promote the escape of pus, but neither then, nor at any subsequent dressing was any water applied. The fractured thigh was supported by a leather splint and a firm roller.

From this time the patient's stumps steadily healed. They were dressed daily with the resin cerate, and union by primary adhesion was gained in a large part of the extent of the suture of both limbs. The rapidity of the pulse gradually lessened, and the temperature declined till it became normal on the seventh day. On the sixth day the diet was increased by the addition of toast and steak. The patient's appetite continued good, and his spirits and confidence in his recovery never flagged. On the 26th day the injured thigh was incased in a plaster-of-Paris dressing. On the twenty-eighth day both stumps were entirely healed. At the end of the seventh week the dressing was removed from the thigh, and the fracture of the former found firmly united, with but little shortening.

The points thought worthy of remark in this case are the slight amount of constitutional disturbance following such grave injuries, and the steady and rapid healing of both stumps.

The promptness with which the oper-

ations were done (three-quarters of an hour after the injury), the excellent constitution of the patient, and the fact that the dressings were untouched for three days, are considered the important factors in the favorable result.

Treatment of Fracture of the Patella by the Weight and Pulley.

At the Presbyterian Hospital two cases of fracture of the patella, under the care of Dr. Geo. F. Shrady, were treated by the weight and pulley. Both fractures were transverse, were occasioned, as usual, by muscular violence, and the fragments were separated three-fourths and one and one-fourth inch respectively. The limbs were elevated on a single inclined plane, and two strong, broad bands of adhesive plaster were applied diagonally to the anterior portion of the thigh, crossing each other just above the patella, and embracing a pad at the upper margin of the upper fragment. These bands terminated in loops on each side of the leg, and were attached to stout cords which passed to a foot-piece and over a pulley to the weights. The lower fragment was merely fixed by a bandage passed around the splint. Extension was made over the entire region of the quadriceps muscle, while the pad applied itself over the upper edge of the upper fragment, bringing it in apposition to the lower fragment. By these means the fragments were maintained in perfect apposition, without discomfort to the patient. Dr. Shrady prefers this method of treatment to any other he has employed.—*Med. Record.*

Fracture of the Base of the Cranium.

Dr. GEO. HALSTED BOYLAND (*Med. and Surg. Reporter*). The symptoms that will assist us in making a diagnosis of fracture of the basis cranii (a condition

of exceedingly rare occurrence, if we exclude gunshot wounds), are briefly as follows :

1. Bleedings from the nose, the pharynx and external ear, of such force and duration that they cannot be attributed to the simple concussion.

2. Suggillations (ecchymoses) in the region of the basis cranii ; these appear during the first days, at a point which the wounding force did not reach—in the eyelids and conjunctiva bulbi.

3. Of great importance is the so-called serous exudation from the external ear. The chemical composition corresponds somewhat with that of the cerebro-spinal fluid, and in almost all cases where the autopsy has been carefully made, the local conditions of the wound prove themselves favorable for its outlet. The prognosis is always grave. Besides the concussion and wounding of brain substance usually accompanying fractures of the basis cranii, the dangers of pyæmia from supuration of the bone, and of the inflammation spreading from the place of fracture to the meninges and brain, are to be feared.

Treatment.—Rest and keeping the head in such a position as will insure the most probability of the fractured pieces being in contact. All bodily or mental exertion must be avoided, low and restricted diet, with gentle purgatives, in order to prevent congestion of the head. Cold applications may be used cautiously, as by a too indiscriminate use of ice the reproduction at the point of fracture is hindered and necrosis caused. For the same reasons calomel and venesection should be very leniently resorted to, even when necessary. The use of the trephine may be indicated when the fracture causes brain trouble, and does not gap sufficiently to allow the pus to flow out of the depth.

Manipulation of the Scapula in Dislocation of the Shoulder.

The patient being completely stripped as far as the upper part of the body is concerned, is either made to lie on a couch or a bed, or he can be easily manipulated in a sitting posture. Take for example, dislocation of the left shoulder. The left wrist is grasped with the left hand, and the arm gently abducted ; the fingers of the right hand are then firmly pushed between the head of the humerus and the wall of the thorax, when, with a sweep of the arm across the body, the head of the bone is easily lifted and slides into the glenoid cavity.—*British Med. Journal.*

Cure of Aneurism of the Aorta by Galvano-Puncture.

By Dr. RICHARD CAMERON, of Valparaiso, Chili. The patient was a man of forty, with an aneurism of the ascending arch. The usual remedies were tried without success, and galvano-puncture was finally resorted to.

Two fine steel gilt needles were used, passed into the aneurism, and kept there for twenty minutes. In about two weeks the tumor began to flatten, and all bad symptoms gradually and permanently disappeared.

The curious and instructive point is that, after removal of the needles, it was found that almost no current had been passing, owing to a defect in the battery.—*Med. Record.*

Empyema.—Free Incision vs. Aspiration.

A correspondent of the *British Med. Journal* writes :

James W., aged seven years, was seized with pleuro-pneumonia, from which he apparently recovered and began to run about. Twenty days after he had been last seen, his father came (he lived about

five miles in the country) and complained of the boy's breathing becoming more and more embarrassed. The little patient was again seen, and dullness had returned to the left side, the side originally affected, and breathing was more hurried. He was blistered and put on diuretics, but still the symptoms of compressed lung increased, and no doubt was entertained but that he was suffering from empyema; and on September 3d his breathing was forty-five to fifty per minute; pulse so quick that it could not be counted; complexion livid. Thirty-five ounces of pus were drawn off by means of the aspirator, with of course immediate relief to the patient. For two days the little patient improved, but diarrhœa, a distressing symptom from the first, still continued. After this, however, he became more restless toward evening, and dullness increased so that on the seventh day after the operation had to be repeated, and with a result differing from the former only in the quantity (thirty ounces) of pus withdrawn. In thirty-five days the operation was repeated five times, and nearly two hundred ounces were taken from the cavity. After each operation the patient experienced great relief, and improved, though so slowly that it was deemed advisable to make a free incision. This was done between the fourth and fifth ribs, about one inch and a half posterior to the mid-axillary line, and a drainage-tube inserted. The child improved every day after this operation; and a very notable feature in the case, the diarrhœa, which had hitherto baffled every attempt to arrest it, ceased.

The wound in the chest-wall soon healed, and when last seen, with the exception of the left side of the chest being flat, the boy looked and felt well.

No antiseptics were used, so that the admission of fresh air into the pleural

cavity is not so much to be dreaded as pent-up matter.

The Surgical Treatment of Empyema.

Dr. C. GERHARDT (Wurzburg). Small empyemata may be cured either by absorption or perforation through the lungs.

Operative treatment is absolutely necessary either when pulmonary or circulatory trouble threatens life, or when all other treatments have failed.

Thorough aspiration of the pus may lead to cure. In many cases, however, it does not suffice.

Free opening into the pleura and frequent washing out with antiseptic solutions is not free from danger nor always reliable. The best methods consist in opening and emptying the chest under antiseptic precautions, or in washing out the pleural cavity and with the exclusion of air.

Very early childhood gives less favorable, the middle period of childhood more favorable, results than adult age. —*N. Y. Obstet. Journal.*

Pulmonary Cancer.

SÉE (*L'Union Médicale*) claims that the following points are of value in the diagnosis of pulmonary cancer: (1) A considerable amount of dyspnoea of a permanent character. (2) A sanguinogumous expectoration. (3) Considerable pain. (4) Dullness which does not elect any particular place, but develops and grows with the neoplasm, and is found but on one side of the thorax. (5) The vesicular murmur is not present. (6) Local fremitus is not to be detected. (7) Slight displacement of the adjacent organs occurs. If the cancer be what Sée styles compressive, œdema or dysphagia may occur; and also variation in the radial pulses, if it presses on the subclavian artery.

Phthisis is diagnosticated from pulmonary cancer in the character of the expectoration, in the lesser amount of dyspnoea, by the quantitative difference in dullness, and by the difference in the soufflé and fremitus. The bronchial gland affections differ from the compressive type of pulmonary cancer by giving rise to not so intense symptoms. Aneurism of the aorta differs from pulmonary cancer in the presence of aortic bruit and pulsation. While these points are of value in differential diagnosis, it is obvious their value is not absolute, as the cancer must have attacked the pleuræ to have produced pain, and the other symptoms will also be somewhat varied by the position of the neoplasm. Perhaps a good way of supplementing the diagnostic points given would be by a microscopical examination of the sputa.—*Chicago Med. Review.*

Cancer of the Kidney from the Irritation of a Calculus.

A specimen supposed to illustrate this was recently shown to the Pathological Society of London by Dr. N. MOORE. It is a most interesting point, as bearing on the general etiology of cancer. In the specimen mentioned, the kidney was very much enlarged, and its pelvis was occupied by a calculus weighing about three ounces and a half. There was some calculoid material plugging the ureter, which was considerably thickened. There were no secondary deposits. Microscopically, the new growth was found to be epithelioid, originating in the kidney tubules. It was no doubt, therefore, a primary cancer of the kidney, apparently resulting from the long-continued irritation of the stone. The patient was only twenty-five years of age. Many years ago, when a child, he had fallen from a

swing, and had complained of kidney pain, and had since passed blood in his urine, and also pus.—*Med. & Surg. Reporter.*

Treatment of Hydrocele.

Dr. T. L. OGIER (*Gaillard's Medical Journal*) recommends the injection of thirty drops of strong compound tincture of iodine into the distended vaginal sac, without previous evacuation of its contents, as a simple method of curing hydrocele without confinement of the patient. It may be necessary to repeat the injection three or four times at a couple of days' interval.

Treatment of Goitre by Iodoform.

M. BOECHAT (*Correspondens-Blatt für Schweizer Aerzte*) has employed iodoform in the treatment of goitre. (1) By external application the author has employed a glycerole covered with a layer of collodion; the results were nil in old cystic or parenchymatous goitres. In recent goitres, on the other hand, of soft consistence, the tumor diminished more rapidly than with iodine or iodide of potassium. The odor is a serious inconvenience. (2) Internally, Boechat prescribes iodoform in pills of one centigramme, not more than ten a day. This treatment has only been applied in the case of two patients with old-standing goitres. (3) M. Boechat has employed interstitial injection in three cases. The first patient, who had a goitre from infancy, received for fifteen days the injection of half of a Pravaz syringe of a saturated solution of iodoform in ether. Cessation was necessary on account of very intense inflammatory reaction, but the goitre was markedly diminished. In the second case two injections were sufficient to cause amelioration in an old-standing goitre. In the third case, a very old goitre, suppuration took place,

with no improvement. To sum up, M. Boechat believes that this is a useful method, which might become more general.—*Medical Press and Circular—Medical Times.*

Caries of the Spinal Column Without Suppuration Presenting Externally.

CASE I.—Patient, a man aged sixty-nine. After exposure to cold and wet he felt pains across the lower part of the back. A month later the inferior extremities became weak, and dragged slightly. Sensation was impaired; numbness, first noticed in the toes, crept up both limbs. He had starting of the limbs at night, straining in micturition, and afterward constipation. On examination, motor power and sensation of the lower limbs were very limited, reflex action being increased. Shortly after he had retention of urine, three months before death, and one year after the first symptom there appeared a prominence of one of the lower dorsal spines. There was a sensation of constriction around the abdomen. Fifteen months after the initial symptoms he died from exhaustion. On post-mortem two abscesses were found, one on either side of the spinal column and communicating with each other, containing pus mixed with bone fragments; the cartilage between the tenth and eleventh dorsal vertebræ had disappeared; the tenth vertebra was eaten away in its lower surface. Above the point of disease the membranes and cord were normal; below, the dura mater was thickened and adherent to the spinal canal by means of an inspissated layer of pus, mixed with bone spiculæ; the cord was slightly softened. The lungs showed evidence of old trouble.—*N. Y. Med. Jour. & Obstet. Review.*

Excision of the Whole Tarsus.

A girl with an indolent, semi-elastic swelling, involving the entire ankle joint, came under the author's care. The malleoli were sawn off, the os calcis was dissected out subperiosteally, and the remaining bones were removed with gouge, forceps, and knife. No tendons were cut. The wound entirely healed, and the patient now walks well. There appears to be a new osseous growth; the situation of the tarsus is occupied by a solid mass. She has complete control over the toes, and a fair movement exists in the present ankle joint.—*Ibid.*

Lymphoma.

PROF. GROSS (*Med. & Surg. Reporter*). William F., aged forty years, admitted to the hospital one month ago, and whose history is somewhat as follows: "About one month ago he first noticed a swelling upon the right side of the neck. Since then it has increased in size at irregular intervals, with the varying condition of the atmosphere; having a tendency to swell rapidly in damp weather, and apparently remaining stationary during dry states of the atmosphere. His family history is good, there being no evidence of the existence of pulmonary or scrofulous disease, and he denies having ever had syphilis.

Upon the right side of the neck a tumor is formed, which rolls about easily under the fingers, thus showing that it is not adherent to the deeper seated structures. The mass is soft; it is glandular, and is composed of the superficial lymphatic glands of the neck, which are placed along the course of the external jugular vein and rest down upon the posterior margin of the sterno-cleido mastoid muscle. There is also detected, by running the hand well down into the supra-clavicular re-

gion of the right side, a solitary enlarged gland. On turning the head and looking upon the left side of the neck, the corresponding glands are seen to be similarly affected. They are also soft and movable, but the enlargement is as yet only slight. Such tumors are called lymphomas, and for the reason that they are composed mainly of enlarged lymphatic glands.

Treatment.—This man was placed upon a general tonic plan of treatment, of the tincture of the chloride of iron and quinia, with good diet and open air exercise. He was also given Fowler's solution, beginning with five-drop doses and regularly increasing the amount until the toxic effect, as evidenced by swelling of the eyelids and vomiting, was produced. German writers have great faith in arsenic when pushed to its limit, and particularly so in the malignant forms of lymphoma, but little was accomplished, however, in this case until one week ago, when the local application of the following ointment was made:

R. Iodoformi, 3 iss.; extracti belladonnæ, 3 ij.; balsami peruviani, 3 j.; unguenti petrolei, q.s. ad. 3 ij. M. Fiat unguent.

The effect of the daily use of this ointment was most striking. In three days the tumor had diminished one-third in size, and to-day, one week from the time the ointment was first rubbed to the surface of the tumor, it is less than one-half its original size. The application of this ointment will be continued, and in addition the hypodermic injection into the substance of the gland, of five minims of Fowler's solution daily, will be advised. The progress of this case will be watched with interest on account of the marked effect of the ointment employed.

A New Method of Treating Subcutaneous Nævi.

Dr. C. COOMBS (*London Lancet*). About a year ago, a child aged nine months was brought to me with a nævus about three-quarters of an inch in diameter filling up the fossa on the left side of the nose. The swelling was entirely subcutaneous, and it was evident that none of the applications which cure the superficial form of the disease would be of any use. Two lengths of No. 24 silver wire were then passed through the middle of the swelling, parallel to each other, and about a quarter of an inch apart. The zinc and carbon of a Bunsen cell (quart size) was then connected with the ends of each wire separately. The result was great heat in the wire during the short period, one or two seconds, of connection. The ends of the wires were then tightly twisted together, protected by being covered with lint and plaster, and left for the next application, which took place a week later. The current was applied three times altogether. The wires were removed after the third galvanization, and no further treatment was needed. The nævus is now scarcely perceptible.—*Ibid.*

Treatment of Carbuncle.

Dr. S. BARUCH (*American Medical Bi-Weekly*) says that the carbolic acid treatment of carbuncle is of great value. The pure carbolic acid liquified and held in liquid form by a few drops of glycerine, is freely carried by a camel's hair brush into every open point, after the slough channel has been cleansed by a pointed tent of linen. This application must be made thoroughly, but very gently. The pain will not be severe, and its necessary daily repetition will not be dreaded by the patient.

After this application, collodion is freely brushed, in three or more successive coats, over the entire diseased surface, extending a few lines beyond the outline even. A doubled piece of linen, having a central opening to admit the sloughing portion of the carbuncle, is now laid upon the collodion-covered surface. A light flaxseed poultice is placed over the former, and renewed several times a day. Muriated tincture of iron and quinine, milk, and any nutriment the patient can be induced to take, should be freely administered. Anodynes should be prescribed whenever necessary, with a view to allay pain and prevent loss of sleep, but are rarely needed after the first day. If the case progresses favorably, the collodion dressing is continued daily, but the carbolic acid may be omitted every other day.—*Chicago Med. Review.*

DIGESTIVE TRACT.

External Hemorrhoids.

CLINIC OF PROF. GROSS.

As I separate the buttocks of this man, you will be able to see upon the right side of the anus an external pile, or hemorrhoid. The condition is a very simple one, it is nothing more than a clot of blood, which has been thrown out under the skin among the subcutaneous cellular tissues from the rupture of a hemorrhoidal vessel. It is due, in the vast majority of cases, to straining efforts while at stool, during a condition of constipation. The passage of hardened fecal matter is always irritating to these little tumors, causing them to be more or less congested and frequently acutely inflamed.

This little tumor has only existed since yesterday, and I can scarcely say whether it is ripe yet or not. If an external hemorrhoid is opened before it is

ripe, troublesome hemorrhage is very apt to ensue. And the means necessary to control this hemorrhage would only increase the severity of the already existing condition of affairs.

What I mean by an external hemorrhoid being ripe, is that the clot should be well formed. This point can always be ascertained by carefully examining the density of the tumor. If it is firm, hard and full, like a shot or bullet, when between the fingers, it is perfectly safe to remove it; but if it is soft and easily compressible it had better be allowed to remain and ripen.

When these tumors are small and recent, the local application of the compound ointment of galls answers very nicely, but when they are older, some operative procedure must be instituted. The old way of treating an external pile, by cutting it off with a pair of scissors, and then allowing the parts to heal by the granulating process, is a barbarous mode of procedure; and the new way of treating them, by the hypodermic injection of strong carbolic acid, can scarcely be any better. By far the more satisfactory plan is to lay the tumor open, turn out the clot and make local applications of lead-water and laudanum or Goulard's extract. This is what will be done in the present case.—*Ibid.*

Cure of Hemorrhoids by the Hypodermic Injection of Carbolic Acid.

Dr. E. ANDREWS thinks that if the following rules are observed, treatment by hypodermic injection will be less painful than other methods and just as safe:

1. Inject only internal piles.
2. Use diluted forms of the remedy at first, and stronger ones only when these fail.
3. Treat one pile at a time, and allow from four to ten days between the operations.

4. Inject from one to six drops, having smeared the membranes with cosmoline to guard against dripping. Inject very slowly and keep the pipe in place a few moments to allow the fluid to become fixed in the tissues.

5. Confine the patient to bed the first day, and also subsequently if any severe symptoms appear. Prohibit any but very moderate exercise during the treatment.

He concludes that this mode of treatment is a valuable contribution to surgical knowledge, and that it will become one of the permanent operations. It is performed as follows: The pile is exposed and the anus smeared with an ointment to prevent smarting should any of the fluid happen to drop. The solution may vary in strength from one part of the crystalized carbolic acid to thirty of olive oil or glycerine, up to equal parts. A sharp-pointed hypodermic syringe is charged with this liquid and introduced. A few drops are thrown into the tumor, the instrument is held in position for a few moments before it is withdrawn. The pile turns white and may wither away without pain, suppuration or sloughing. Only one pile is treated at a time. About a week should elapse between sessions. Most cases suffer from sharp smarting sensations, which are, however, temporary. A few suffer intense pain. The majority are cured without interrupting the patient's business.—*St. Louis Clin. Record.*

Perforation of the Intestine by *Ascarides Lumbricoides*.

Dr. E. MARCUS, of Frankfort am Main, reports in *Deutsches Archiv für Klinische Medicin*, the case of a girl, aged thirteen and a half years, of healthy family, but since her fifth year excessively given to the practice of onan-

ism, for which various kinds of vermifuge had been frequently prescribed without any worm having ever been observed in her stools. In the morning of April 7th she had gone to school in her usual good health, but returned home at noon complaining of severe pains in the abdomen, which in the course of the afternoon gradually increased. She also vomited several times a greenish substance. In the evening, when the Doctor was called, she was in such pains that an examination was impossible. The bowels were moved with an enema of ol. resini. The next day the abdomen was greatly distended, and painful to such a degree that it could not be touched. The face was pale, pulse small, and feet cold. Perforative peritonitis was diagnosed. After seven days of terrible suffering she died from collapse. At the autopsy, twenty-eight hours after death, an enormous quantity (considerably more than one gallon) of highly offensive pus was found in the peritoneal cavity, but no fæces. Between the intestinal convolutions were found three large round worms, two of which were dead, while the third showed signs of life. In the descending portion of the duodenum, about $4\frac{1}{2}$ cm. below the first flexure, was found, on the inner side, a perforation of about 6 cm. in length. Such cases are unquestionably rare.

VENEREAL DISEASES.

Insanity Resulting from Syphilis.

M. BALL has given a résumé of Fournier's views on insanity attending syphilis, which, according to that observer, presents itself either as syphilitic dementia, as mania, or as general pseudo-paralysis.

In syphilitic dementia the patient's temperament undergoes a radical change.

His intelligence is clouded and his conduct strange. He becomes moody and taciturn. Labor is fatiguing and intolerable. His memory fails, though judgment often remains. Loss of memory may be either sudden and complete, or gradual and imperfect. The patient becomes careless as to his personal appearance, and very irritable. This condition may be designated as a precocious senility of the mind, differing from senile dementia, however, in being curable.

Syphilitic mania may be suddenly developed or present prodromal symptoms. The latter, when present, consist in a peculiar excitement, feverish activity, and in unusual loquacity. These prodromata terminate in delirium, which may manifest itself in several forms. Sometimes it is active and attended by complete insomnia. The patient becomes destructive, and suicidal tendencies show themselves. The delirium assumes the form of hypochondriasis or syphilophobia. The patient believes himself persecuted. The delirium is impulsive.

General syphilitic paralysis. This variety of the disease begins with mental hebetude and with incoherencies of speech. The speech may become embarrassed, and stuttering, due to local paralysis, appears. Other partial paralyses, particularly those of the eye, soon follow. The diagnosis is based upon the concomitant symptoms, as headache, alopecia, and gummata, but particularly upon partial paralyses. Strabismus is another valuable diagnostic symptom.

The prognosis is favorable if the case receive prompt treatment, although the disease sometimes terminates fatally. The treatment must be energetic and thorough. At the beginning the mixed treatment is indicated: 5 grms. (75 gr.), at least, of the iodide of potassium should be exhibited daily, and inunctions also employed. If mercury is not

well tolerated, recourse may be had to the chloride of gold.—*Annales et Bulletin de la Société de Médecine, de Gand*, July, 1881.

Constitutional Syphilis—Sulphate of Copper.

MM. AIMI, Martin and Oberlin, physicians at St. Lazare, say: We have had the opportunity of treating, since September last, for different syphilitic symptoms, secondary and tertiary, fifteen patients who left the service cured; indeed, we have had twenty-two patients under treatment by this method. The results obtained by sulphate of copper are as satisfactory and as reliable as could be desired. On comparing, in a certain number of females afflicted with the same symptoms, almost alike in every particular, the action of the mercurial salts with that of the cupric salts, that of the latter has appeared superior in efficacy and rapidity in nearly every case.

Our patients have borne with the greatest ease this new method of treatment. In one case there commenced at the outset nausea of trifling significance, which did not, however, prevent tolerance from being established in three or four days.

In one case of severe syphilis (ecthy-ma and rupia, gummy tumors, etc.), in a woman belonging to the service of Dr. Bonrean, with whom the classical treatment had been powerless to modify her condition, the sulphate of copper, given for the first time February 29th last, has brought about rapid and complete cure.

In two or three of our patients we have observed, as a symptom of cupric saturation, a gingivitis similar to that which mercury produces, characterized by a symptom in every way peculiar to it; that is a *green line* running along the free border of the gums. We can add that this cupric gingivitis yields to treat-

ment much more rapidly than is usual with mercurial gingivitis, and that in the two or three cases in which we have observed it, it has presented no threatening symptoms, nor is it ever accompanied with fungosities and softening of the mucous membrane.

The innocuousness of treatment seems to us to be easily explained by the small doses of sulphate of copper which we have employed. We have given it internally in solution of distilled water, in doses of four, eight and at most twelve milligrams daily, and externally by means of baths, medicated by twenty grams to the bath.—*L'Abeille Medicale*.—*Nashville Jour. M. and S.*

Syphilitic Mania. Complete Cure by the Mixed Treatment.

The following case is reported in the *Revista Frenopatica Barcelonesa*. The patient was a young Spaniard, who had served six years in the Cuban campaign. Being entrusted with the treasury of two regiments, and executing his duties with great zeal, his position was the cause of mental fatigue. This probably brought about a cerebral congestion, which was followed by epileptiform seizures, extending over quite a space of time. Subsequently a marked change was noticed in his disposition. Melancholia, loss of memory and other symptoms of acute mania, together with an ambitious delirium, rendered it advisable to place him in an asylum. There it was observed that the elementary mental faculties were unaffected, but that the higher ones, reason, judgment, casuality, etc., were completely deranged; association of ideas and co-ordination were lost. Acute general mania, with acute ambitious delirium and hallucinations, was diagnosticated, and ascribed to the common causes. Accordingly, opiates, chloral, and other nervous sedatives

were exhibited, but only seemed to aggravate the malady. Finally the use of the straight-jacket became necessary. The patient gradually failed and became emaciated; sores appeared upon the sacrum, and death was near at hand. At this juncture it was ascertained that the man had had syphilis, and the cause of the mania was patent. Under the use of the iodide of potassium, associated with hypodermics of corrosive sublimate, the effects of treatment were evident in a few days; the fever and delirium were diminished in intensity, the autophagism ceased and the character of the sores changed. At the end of three months the patient was dismissed cured.—*Med. Record*.—*St. Louis Med. and Surg. Record*.

Potts' Disease of Syphilitic Origin.

Professor FOURNIER has observed the following rare cases (*Annales de Dermatologie*):

A man, aged 55, of athletic build, has noticed the state of his health change since several months, without being able to assign any cause therefor. He has become thin, enfeebled to such a degree, that he could scarcely walk when Prof. Fournier saw him for the first time. He had lost his appetite; besides, he complained of lumbar pains which were constant and of a dull heavy character, in general; but at times, very acute and extending to the lower limbs.

Specific sarcocoele, gummy tumors and ulcerations, etc., were found, and energetic treatment immediately instituted, but it failed to retard the cachexia which carried off the patient a few months later.

The post-mortem demonstrated, besides the lesions we have mentioned, syphilitic changes in the liver and kidneys, gummy products on a plane with the lumbar nerve, and above all multiple

and considerable lesions of a Potts' disease, affecting the spinal column at the second, third and fourth lumbar vertebræ and of incontestably specific origin.—*St. Louis Med. and Surg. Record.*

Neuralgic Headache with History of Syphilis.

R. Liq. potass. ars. 3 j.; tinct. quiniæ, 3 jss.; hydr. bichloridi, gr. ½; aquæ, ad. 3 vj. M. Sig.—A teaspoonful in a wineglassful of water three times a day after food.—*Hosp. Gazette.*

Pharyngeal Stricture.

Dr. LANGREUTER (*Deutsches Archiv. f. Klin. Med.*)

The person was a young man 29 years old, for some years subject to syphilitic symptoms. The stricture gradually progressed until he was in immediate danger. Tracheotomy was then performed and a tube inserted. The patient recovered promptly, and under the usual specific treatment the general symptoms disappeared. The stenosis arose from a ring-shaped cicatrix, which contracted in healing.

Treatment of Tertiary Syphilis.

M. HARDY, as we read in *la France Médicale*, uses very frequently the following solution:

R. Potass. iodid., 3 vss.; hydrarg. biniodid., gr. ij.; aquæ destil., 3 x. M.

Of this solution a tablespoonful may be taken at first, one in the morning, another at evening.—*Med. and Surg. Reporter.*

On the Value and Safety of Administering Large Doses of Iodide of Potassium in the Late Lesions of Syphilis.

Dr. M. H. HENRY gives the history of a very interesting case of dementia and hemiplegia due to syphilis, in which small doses of iodide of potassium had failed to effect little, if any, improve-

ment. Beginning with thirty-grain doses three times daily, and gradually increasing both the quantity of each dose and their frequency of administration, until three hundred grains per day was reached, there began to be a marked daily change for the better. In this case, as the doses were increased, the improvements were most marked. The patient took three hundred grains daily for more than eight weeks, and with the disappearance of the syphilitic symptoms, he gained steadily in his general health and in flesh.

He was discharged, cured, nearly ten years ago, and has enjoyed good health ever since. He is stout and hearty, and is in full possession of all his faculties, and has been for many years attending to his business. He bears no evidence of any syphilis, and certainly none of any disease of the kidney; nor was there any albuminuria during the time he was under treatment. The doctor adds, that he frequently meets patients who were under his care as far back as 1864, and who, in the course of treatment, have taken very large doses of the iodide. They are invariably doing well, and bear no evidence of disease of the kidney or any lesion of syphilis.—*Ibid.*

Treatment of Gonorrhœa by Injections of Sulphurous Acid Diluted with Water.

W. D. WILSON, M.B. (*London Lancet*). The rules of treatment I recommend are: place the patient on low diet, and administer injections of sulphurous acid diluted in water one to fifteen, three times a day, no other treatment being necessary. I find it is necessary for the attendant to give the injections, for if it is done by the patient it is never well done, most of the fluid escaping back outside the nozzle of the syringe. The injection should be kept

in the urethra from three to five minutes. If the patient complains of much pain, or if there is a tendency to chordee, it will then be sufficient to administer the injections once or twice in twenty-four hours.

If these instructions are strictly followed, the purulent discharge will become scanty at the end of the first day, and on the third it will be replaced by a thin, gleety discharge, which also disappears in a couple of days. While this watery discharge lasts I usually administer only one injection daily. I find that the first injection frequently causes pain, which is not so much complained of afterwards. I, therefore, in a few cases, give the first injection very much diluted—one in twenty, afterwards using one in fifteen. It is necessary to see that the sulphurous acid is fresh and good before it is diluted to the required strength.

Gonorrhœa.

Dr. A. V. BARNES (*Medical Brief*) has found the following injection, used four or five times after urinating, very valuable in the subacute stage of gonorrhœa:

℞. Plumbi acetat., ℥j.; zinci acetat., ℥j.; morph. acetat., ℥j.; acid acetic, f 3 ss.; aquæ, f 3 vj. M.

With this he gives, internally:

℞. Potas. bicarb., 3 iij.; tr. columbi., f 3 v.; aq. dest., f 3 j. M.

Sig.—Dessertspoonful four or five times daily.

The Treatment of Gonorrhœa.

Dr. W. WATSON CHEYNE (*British Medical Journal*, July 24, 1880). Acting upon the known effects of certain antiseptic materials, he decided to adopt iodoform and oil of eucalyptus. In order to bring them into certain contact with the suppurating surface, he had bougies made of these materials and

cacao butter. The formula is—5 grains of iodoform, 10 minims of oil of eucalyptus, and 85 grains of cacao butter. This bougie is introduced into the urethra, and a strap and pad over and around the orifice retains the bougie there until it dissolved. After this, an injection of boracic lotion (saturated aqueous solution of boracic acid) or an emulsion of eucalyptus oil (one ounce of eucalyptus oil, one ounce of gum acacia, water to forty or twenty ounces), to be used for two or three days. At the end of that time injections of sulphate of zinc, two grains to the ounce, may be begun. For a day or two the purulent discharge continues, but afterwards it steadily diminishes in amount, becoming in four or five days mucus, and ceasing altogether in a week or ten days.—*Can. Med. Record*.

Therapeutic Notes.—For Chordee.

℞. Amyl nitrite, gtt. iij.-v.

Said, by a writer in the *Medical Record*, to be a very effectual remedy in chordee and painful priapism.

Irritability of the Sexual Organs, with Nocturnal Emissions.

℞. Camphoræ, grs. v.; ext. opii., grs. j.; pil., hydrarg., grs. iv. M. Divide into two pills, and order them to be taken at bed time.

DISEASES OF EYE AND EAR.

Value of Operations in which the Membrana Tympani is Incised.

At a meeting of the American Otological Society at Newport, Dr. D. B. St. John Roosa read a paper on "The Value of Operations in which the Membrana Tympani is Incised," in which is formulated his experience as to the worthlessness of all operations on the membrana tympani in all chronic cases

in which there are no fluid accumulations in the tympanic cavity. Nearly every member present agreed with his opinion. In curious *contrast* to this unanimous expression of opinion is the discussion of the same subject in the section for diseases of the ear at the International Medical Congress at London, in which Dr. Guje, of Amsterdam, who introduced it and spoke *favorably* of it in several classes of chronic middle ear disease, and is supported in these views by Dr. A. Paguet, Professor of Medicine in the Faculty at Lille, and by some others who took part in the discussion. We believe that further experience will substantiate the views of American otologists.—*Dr. A. Mathewson.*

Unique Case of Dislocation of both Lenses into the Anterior Chamber.

Dr. A. W. CALHOUN (*Atlanta Medical Register*, Oct., 1881). A man thirty years of age, stout, healthy, *extremely near-sighted* since early life, by severe lifting ruptured the suspensory ligament and forced the lens through the pupil into the anterior chamber. The conjunctivæ were much inflamed, photophobia and lachrymation existed to a painful degree, pupil was widely dilated, vision practically gone, owing to beginning opacity of the lens. An opening was made at the lower corneo-sclerotic junction and the lens removed. By the aid of *convex* glasses the vision was brought up to $\frac{30}{60}$. Soon afterwards he dislocated the *other lens* into the anterior chamber by jumping upon a rapidly moving train. By the same operation an equally good result was obtained. In this case a near-sighted person, with defective vision, becomes by accident far-sighted, with almost normal vision. The Doctor remarks in conclusion that myopic balls are more subject to dislocation of the lens than any others, due

probably to weakening of the suspensory ligament through diseased elongation of the ball, which occurs in all cases of myopia.

DISEASES OF THE SKIN.

Oleate of Zinc in Eczema.

Dr. SAWYER (*Jour. Mat. Med., April*) records his testimony in favor of the efficacy of the ointment of oleate of zinc in the treatment of eczema. He has used the remedy for nearly six months, in a large number of cases arising in hospital and private practice. The author has always used the oleate of zinc made into an ointment, either with vaseline or with lard. The preparation with vaseline he has employed in private practice, and that with lard, on account of its comparative cheapness, for hospital patients. Vaseline is preferable to lard, because it is not so liable to change. Lard sometimes disagrees with the skin. The oleate of zinc is serviceable in the treatment of eczema capitis of children.—*Braithwaite's Retrospect.*

Palmar Eczema.

In *L' Union Medicale* we find the following treatment, that of Drs. LUSH and LIVEING. The following lotion is used to calm the intolerable itching, in chronic eczema of the palm of the hand:

R. Sodæ bicarb., 3 ij.; potash bicarb., 3 j.; glycerin., 3 j.; tr. opii, 3 iss.; aquæ, 3 viss. M. In very obstinate cases, where the skin has become very fragile, Dr. Liveing recommends the following solution:

R. Liq. potass., 3 iss.; aq. destill., 3 viss. M. This should be used as a lotion until the skin commences to peel off.

He has also found that rubber gloves were of benefit. The internal administration of arsenic proved efficacious.—*Med. and Surg. Rep.*

SURGERY.

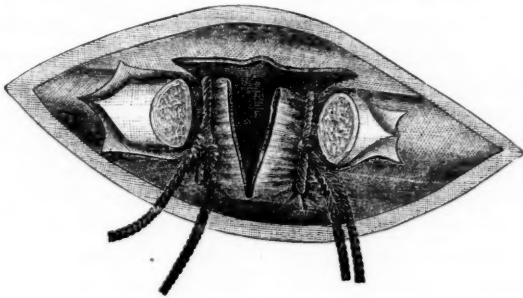
FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Drainage-Tube in the Chest for Two Weeks. —Resection of a Rib necessary for its Removal.

Dr. ROBERT ABBE, New York (*Med. Record*): One of the risks attending the drainage of large cavities by rubber-tubing, if imperfectly guarded, is illustrated by the following case :

A boy, nearly five years of age, was

January 28, 1882.—The boy was etherized. On examination I found a sinus over the ninth rib, in the axillary line. The bone was bare, and a probe passed above it, into the pleural cavity, but revealed nothing that felt like a tube. The sinus was dilated, and dressing-forceps, curved and straight, were used without discovering the tube. As the eighth interspace was much too small to admit the finger for exploration, I excis-



the subject of empyema of the left pleural cavity, for which his physician incised the chest-wall in the eighth intercostal space, two months ago. There was a free evacuation of pus, and a drainage-tube was inserted. This served well for six weeks, when one morning, on changing the dressing, the tube could not be found. The mother had frequently noticed that, on coughing or deep breathing, it was sucked in or pushed out a couple of inches, and felt sure it had slipped in in this way. The child then began to cough "almost every five minutes;" the sinus became smaller, pus was poorly evacuated, and hectic set in. Two weeks later I was sent for by the physician to remove the tube "if it was in the chest."

ed one inch of the ninth rib after the following method : An incision, two inches long, was made down to the bone. Its periosteum was stripped back and the rib gnawed away by *Rougeurs* and *Langenbeck's* gouge until its entire thickness, one inch in length, had been removed. Considerable care was required in pressing the periosteum and pleura away from the internal face of the rib. The original sinus, in the eighth interspace, was then enlarged by lateral cuts of the intercostal tissues, and, by an aneurism needle, two stout ligatures passed into the cavity at either side of the wound, were brought out in the ninth space, near the cut ends of the rib. These, when tied, involved the pleura-subcostal periosteum and inter-

costal vessels. The part between the ligatures was then cut through, well into the ninth space, and this opening, gained without hemorrhage, readily admitted the little finger. The tube was felt lying on the posterior wall of the cavity, parallel to the spine, a finger's length from the opening. It was quickly fished out by a stout bent probe and forceps, and found to measure *seven inches in length*.

A quantity of fetid pus and decomposing clot was evacuated, and the secretions allowed to discharge into loose oakum. The accidental introduction of a drainage-tube into a cavity, which it is designed to empty, ought not to happen, if its end external to the wound be transfixed by a "safety-pin" or needle, which will lie flat on the skin, and should not cross the lumen of the tube.

A Case of Herniotomy, with Wounding of the Obturator Artery. Recovery.

Dr. E. H. BARTLEY (*Annals of Anat. and Surg.*): Owing to the peculiarities in the origin of the obturator artery, it is in great danger of being wounded in operations upon femoral hernias. In the following case, the patient was persuaded, after thirty-eight hours from the beginning of the distressing symptoms, to allow an operation. The tumor at this time was about twelve centimetres long by six wide, extending from the middle of Poupart's ligament towards the scrotum. The patient positively stated, when questioned, that the tumor descended, as it enlarged in size, directly towards the scrotum. The tumor was movable, and gave a tympanitic percussion note. It seemed to diminish in size above, but the thickness of the fatty walls prevented it from being grasped.

After being brought under the influence of an anæsthetic, an incision was made over the most prominent portion

of the tumor, extending obliquely from above and outward, downward and inward about seven centimetres. A strong antiseptic spray was used during the operation. On opening the sac a little blood-colored water was poured out, and about thirty centimetres of the intestine was found outside of the ring, which was covered with a little coagulated fibrin. It was dark brown-red in color, and distended with gas. A small piece of the omentum was found drawn down and adherent to the lower part of the sac.

By passing the fingers up to the ring, it entered the crural sheath and determined the diagnosis to be that of femoral hernia. A herniotope was passed into the ring, and several shallow nicks were made in its inner and upper edges by simple pressure upon the knife. This process had to be repeated the third time before reduction was completely accomplished, and the last time a somewhat deeper incision was made downward and inward. When the gut had been entirely returned into the abdominal cavity, a little arterial blood was seen to flow out, which, on deeper inspection, after ligation and separation of the protruding omentum, was found to be quite abundant.

It was evident that the obturator artery had been wounded, and an attempt was made to tie it by drawing the walls of the sac asunder by tenacula, and working through the femoral canal and ring. After some delay and useless effort, this opening was temporarily tamponed, and the first incision was extended about five centimetres upward, and the soft parts divided, layer by layer, down to the peritoneum, exposing the great vessels, just as in the operation for ligation of the external iliac artery. The bleeding artery was soon tied with cat-gut, as also was a severed vein. The

tampon was then removed, and a part of the blood, which had been poured out into the peritoneum, was pressed out by a gentle pressure upon the abdomen. The upper part of the wound was closed by two platinum wire sutures, and, after draining the hernial sac, canal, and wound, the rest of the wound was closed with silk sutures, antiseptic dressing, compression, etc. The progress of the case was afreble, and the whole wound down to the drainage opening healed in nine days, with but two dressings. On the twentieth day the patient was discharged, cured.

Treatment of Hernia.

Dr. H. O. MARCY, in a review of the second edition of Dr. C. H. Warren's work on hernia, in *Annals of Anatomy and Surgery*, gives the following as the treatment recommended and *used by* the author, also a description of the *needle* used for injection.

"The syringe is of careful workmanship, and possesses several advantages which are claimed for it by the inventor. First, the point must be broad and not sufficiently sharp to easily pierce a vessel. It is also flattened upon itself, and has a spiral twist which is said to facilitate very much its introduction. There are several openings upon either side for the escape of fluid, which is intended to infiltrate the tissues surrounding the puncture, and thereby produce an exudative inflammatory process.

"The needle is introduced upon the finger well invaginated within the rings, care having first been taken to carry the peritoneal sac well out of the course of the needle, it being emphasized not to inject or injure the peritoneum, but to infiltrate the wall of the rings and thus produce interstitial thickening and contraction of the surrounding tissue.

The fluid now recommended for injection is:

"R.—Fl. ext. querci albæ, 180 gm.; evaporated to 60.00; alcohol, 90 per cent., 15.00 gm.; ether sulph., .50 gm.; morphia sulph., .25 gm.; tr. veratri viridis, .50 gm. M.—Signa: Inject 15 to 20 drops in small and recent herniæ, 25 to 50 drops in large or old herniæ.

"It is claimed that this is an aseptic fluid, that may be used with safety, and very rarely produces suppuration. Suppuration is always to be deprecated, and when it occurs the result is far less satisfactory. Large or old herniæ may require several injections before cure is complete, and in such cases the injection may be repeated every six or eight months. Subsequent treatment is emphasized. An elastic bandage or truss should be applied soon after the operation and worn constantly when in the upright position, and the patient is to remain under the supervision of the surgeon for not less than one year. Many failures are attributed to the neglect of these precautions. Of one hundred and fifty cases reported and well authenticated, there were only twelve failures."

Strangulated Hernia.

Dr. GEO. JEWETT (*Boston Medical and Surgical Journal*): The patient was about fifty-five years old; had left inguinal hernia for many years, for which he had worn an ordinary truss with perfect relief until within the past four months, since which time the use of truss was unsatisfactory, and he became aware that the hernia could not be fully reduced. April 7th went to bed well; on the morning of the 8th felt pain at epigastrium, with nausea, when the hernia appeared in an unusually large volume, filling the scrotum. He observed it was larger and harder than ever but

fore, but reduced it entirely, as it seemed to him, without much difficulty. He remained quiet the remainder of the day, nothing occurring until the afternoon of the 9th, when the hernia re-appeared larger and harder than ever, and could not be reduced. He soon sent for his physician, who also failed in taxis. At time of my visit there was prostration, nausea, but not much vomiting. The tumor was large, very hard, and not resonant, nor markedly tender. Without effort at taxis I introduced an aspirator needle, and drew, by estimate, about five ounces of bloody serum, which soon coagulated upon standing. Decided to give opiates, apply ice, and wait till morning. Nine A. M.—Patient had nausea; not much pain; had slept some; hands and feet cyanosed and cool; nose and ears cool; was evidently sinking. The hernial tumor was still larger, apparently solid. The patient etherized, instruments and hands carbolyzed, I proceeded to operate without delay. The tissues covering sac were much infiltrated. On opening the sac a jet of bloody serum spurted freely, and a coil of intestine, livid in color, was exposed; two or three long, well organized clots were floating in the serum.

A careful examination of the strangulated gut showed the serous coat had been stripped off for a space one inch in width and two in length. The outer margin revealed a thickened mass of lymph, which had glued the intestine to the scrotal wall, and recently had been torn from its connections. A bloody serum oozed from the abraded surface. The stricture was high up, and when relieved the intestine could not be fully returned. Exploring the region of the obstruction, I found a fibrous band binding the intestine to the abdominal wall as far as I could reach. This I

carefully separated as far as possible with my index finger, cleansed and carbolyzed the parts, and returned the contents to the abdomen without further difficulty. The cut surfaces were carefully cleansed, and as the wound was partially closed the patient began to cough, when considerable bloody serum and clots were forced from the abdominal cavity. After some further delay the dressing was completed. The patient made a good recovery, and a month or thereabout, after expressed himself in good condition for business.

Cases of Papilloma, or Warty Growths on the Lips.

(Clinical Lecture by Prof. Gross.)

Here are two cases, Mary S. and James M., with similar affections upon the lower lip. In the woman, you observe upon the left side of the lip a dark excrescence, not ulcerated. Seven years ago, she says, this first appeared, and after lasting for a short time went away. she saw nothing of it for six years; it returned last summer. The man has an identical growth in the same situation; the two are precisely alike.

What is the character of this growth? It belongs to a class of tumors known, in the books, as *papilloma*. It is a tumor composed of the same materials, very much, as an ordinary wart on the hand. It is particularly apt to come upon exposed portions of the body; it contains a good deal of epithelial matter; it is a corneous structure, resembling the horn of a cow, sheep or goat. Examining a section under the microscope you will find it composed of many flattened epithelial cells, arranged in rings. There is nothing malignant about it at all, and it never assumes such a character.

These horns are apt to appear upon the lips, the forehead, the prepuce, and

upon the trunk. I have one in my cabinet, taken from a lady nearly ninety years of age, which had been growing for many years from the front of the chest, over the ribs, below the mammary gland. They sometimes attain a great length. It is strange how people will allow these tumors to remain; you remember a man whom you had before you about two weeks ago, with a large fatty tumor, weighing ten pounds, which he had carried on his left thigh for upwards of forty years. They will in like manner allow these horns to grow until they become nearly a foot in length, or until they cause discomfort by interfering with the clothing.

I can remove this growth with my fingers; it is ugly and rough looking; not larger than a pea. There is a rough surface at the base of the growth, to which I now apply a pledget of lint wet with ethylate of sodium; an application designed to prevent a recurrence of the growth. It is supposed to possess the property of altering the condition of the part. It has also been used for a similar purpose, in tumors of a malignant character; although, as I told you, there is nothing malignant about this.

The other patient tells us that he has had a similar formation on the lip for about ten months. I shall adopt a different method here, and remove the base of the growth with it. Having the coronary vessels compressed by an assistant, I shall excise it by a V-shaped incision with the bistoury, and close the wound with one twisted and one interrupted suture.—*Coll. and Clin. Record.*

Pulsating Tumor of the Head of the Tibia Treated by Compression of the Femoral Artery.

Dr. J. D. SMITH (*American Journal of the Medical Sciences*), of Friendship, Tenn., records the case of a pulsating tumor of the head of the tibia in a young

man twenty-four years of age, which was treated by compression of the femoral artery with the result of an entire disappearance of the tumor. This success was, however, merely transitory, and eight days afterwards pulsation was again noted, and the leg was subsequently amputated at the knee. With the exception of some hemorrhage on the thirteenth day the patient made a rapid recovery without any bad symptoms.

Lumbo-Colotomy as a Preliminary Measure in Imperforate Rectum.

Dr. W. A. BYRD, of Quincy, Ill., describes an interesting series of procedures, which succeeded in establishing a passage for fæces in the normal situation. Being called to see an infant, two days old, with imperforate anus, he made an incision backward and upward from the anus, to the depth of two and one-half inches. No evidence of intestine being obtained, and the trocar and canula having previously failed to discover intestinal contents, lumbo-colotomy was performed upon the left side. An incision, two inches in length, was made downward and forward from a point over the external border of the quadratus lumborum muscle, and half way between the ilium and the ribs. The left kidney was disclosed in this way, but, by an incision extending one inch farther forward, the descending colon was reached. An oblique cut was then made in it, three-fourths of an inch long, and the edges of the intestinal opening were stitched to the skin at the inner border of the external wound. The wound was well cicatrized in a week, but the bowel would evert to the extent of some two or three inches, giving great pain if the part was not returned and held *in situ* by a pad.

Accordingly a further effort was made about a month later. The finger being passed into the bowel, through the

wound, it was found that the calibre of the bowel easily permitted its passage for about three inches, when it suddenly narrowed. Into this narrow portion was passed a small sound, used as a searcher in infants, and the end of it was worked down in the narrow bowel toward the anus.

An incision, two inches deep, admitting the index finger, was made from the anus to the coccyx, with the view of meeting this instrument from below. Finding that only about one-eighth of an inch intervened between the instrument and the finger, the former was pushed through the intermediate space. To the point of the searcher a short thread was then attached, and this in turn to a No. 10 Jacques' catheter, which was drawn into the passage thus formed, while either extremity projected, one from the upper and one from the lower wound. But a third operation was required to secure the establishment of a more natural outlet for the fæces. Taking a piece of soft-rubber tubing, about a foot long and as large round as the little finger, half an inch of one extremity was tucked up into the tube, making a bulbous extremity. This end was then attached by a stout thread to the catheter and drawn into the bowel. By steady traction the narrowed cul de sac was drawn into the new anal opening and fitted into place, so that there is now a continuity of mucous membrane from mouth to anus.

It is now hoped, and confidently expected, that the first artificial opening will close without further operative interference. In case this hope is not realized, a plastic operation will be resorted to. The infant is now doing very well.—*St. Louis Courier of Medicine.*

Trephining in Skull Fracture.

Dr. DUPLAY (*Archives Générales de Médecine*, January, 1882,) comes to the

following conclusions respecting fracture of the skull, and trephining therefor: First: That far from adding to the gravity of a wound of the skull with limited circumscribed depression and fracture of the internal table, trephining is an operation inoffensive and antiseptic in character. Second: Trephining is a simple operation which does not require rules for guidance other than those resulting from circumstances. It is a "cleaning up" which has the advantage of transforming a complex, not easily manageable wound, liable to gangrene, into a simple aseptic wound which can be easily treated. Third: The study of the depression may lead to some knowledge of the adjacent osseous lesions. Fourth: The comparison of the osseous lesions thus diagnosed and the functional symptoms observed may lead to the recognition of the nature and seat of the cerebral alterations of which the osseous lesions are the cause, and the functional troubles the result. In all skull injuries the fact should not be forgotten that an insidious meningeal change may be set up which would be likely to lead to serious consequences.

Treatment of Hydrocele.

Dr. WEIR (*Cincinnati Med. News*) gives four cases of hydrocele treated in four different ways for their radical cure, viz.: In the first case, injecting the tincture of iodine into the sac containing the fluid; in the second, injecting pure carbolic acid; in the third, injecting a ten per cent. solution of carbolic acid; and in the fourth case, performing Volkmann's operation. In the latter case, there was found to be considerable inflammation and thickening in the sac, and it was not expected that the patient would recover so soon as if it were a simple case. One week later,

the patient on whom the pure carbolic acid injection was made was again presented at the clinic, and the inflammation and enlargement had almost entirely subsided. The advantage of this method over that by the injection of the tincture of iodine was, that there resulted less serous exudation prior to adhesion of the two opposing surfaces of the tunica vaginalis.—*Cincin. Med. News.*

Defer's Method of Treatment of Simple Hydrocele.

Dr. ROL (*Bull. de Thér.*) praises this method of treatment, of which he gives the following description: The hydrocele is punctured with canula and trocar, as usual, and evacuated; through the canula is introduced a sound, on the end of which is fused a little piece of nitrate of silver; the interior of the tunica vaginalis is then rapidly touched at different points with this caustic, when the sound, and after it the canula, are withdrawn. The results of this mode of treatment are said to be excellent. Notwithstanding the occurrence of a sharp inflammation, lasting five or six days, a cure is generally obtained, not by adhesion of the two surfaces of the tunica vaginalis, but by a simple vital modification of that membrane. The return of the effusion is rare. Defer's operation is thus described as perfectly safe, thoroughly efficacious, and easily performed.—*Med. and Surg. Reporter.*

Treatment of Phagedenic Ulcers.

Dr. VIDAL, in *Concours Médical*, recommends:

R. Vaseline, 3 x.; Pyrogallie acid, 3 j.

M. Make into an ointment and apply, morning and evening.—*Med. and Surg. Reporter.*

Successful Skin Grafting.

The *Paris Médical* reports the case of a man, thirty-seven years old, who for over six years had suffered from a varicose ulcer on the left leg. Every form of treatment having been resorted to without benefit, the idea of skin grafting suggested itself to the physician. The ulcer was 14 centimeters by 8. On this six grafts were applied, taken from skin off the abdomen of a young live rabbit, the hair having first been shaved off. Besides these, two other grafts of skin from the patient's fore-arm were also applied, and the parts were dressed antiseptically. After eight days the dressing was removed, and it was found that the six animal grafts had fully taken; they were surrounded by healthy granulations; but the human grafts had not been successful. The dressing having been continued another eight days, inspection showed that the grafts formed a patch of healthy skin in the center of the ulcer, 10 by 7 centimeters. After another week of antiseptic dressing, cicatrization was complete, and when the patient was again seen, two months later, he was entirely cured, and no rabbit hair had grown on the new skin.—*Med. and Surg. Reporter.*

Whitlow.

Dr. CHRISTOPHER HEATH says of this disease that if met with in the earliest stage, when the finger has just begun to redden and tingle, a twenty-grain solution of nitrate of silver, of the silver stick wetted and lightly pencilled over the affected part and a little beyond, checks it at once. When the whitlow is a little more severe—that is, when pus forms about the nail or the tip of the finger—the cuticle, which is insensitive, may be incised. Occasionally, however, when a foreign body has found its way be-

neath the nail, pus forms there and gives rise to excruciating agony from the tension beneath unyielding structures. Judicious cutting away of the nail will relieve this if near the margin; but if near to the base, it is much better to pare down to the nail with a sharp knife until the matter is let out than to resort to the unnecessary cruelty of removing the entire nail.

The third kind of whitlow is really an acute necrosis of the terminal phalanx, following periostitis and suppuration beneath the periosteum, just as it does in the case of a long bone. A very slight injury—the prick of a needle or a pin—may set it up. After some hours' uneasiness, the pain becomes acute and throbbing, and entirely prevents the patient sleeping. If timely relief is not given, pus will very slowly make its way to the surface of the finger, but never up the sheath of the tendons, and, when discharged, will leave the greatest part of the phalanx bare and dead behind it. A timely and free incision is the only mode of saving the phalanx, and cannot be resorted to too early; for, if no pus be present, the inflamed periosteum will still be divided with great relief to suffering. The finger should be held firmly on a table, and the surgeon, entering his knife just above the transverse interphalangeal mark in the skin, should cut boldly down to the bone in its whole length from base to apex. When, as so often happens, these cases have been treated domestically with "soap and sugar" and poulticing until the end of the finger is riddled with sinuses, there is nothing to be done except to extract the necrosed phalanx as soon as it is loose and to bring the finger into shape by careful water-dressing applied in strips. The base of the phalanx usually survives, giving a point of attachment to the tendons.

Inflammation of the skin and subcutaneous tissues may occur in any part of the finger. Incisions must here be made with care, so as not to open the theca or sheaths of the tendons, which then invariably slough, and the patient is left with a useless finger. For this reason incisions on each side of the finger are safer than one in the centre, that may unawares let out the tendons, which will look perfectly healthy at the moment, but soon become sodden and softened.

The synovial sheaths of the flexor tendons of the thumb are often, though not always, in direct communication with the synovial membrane of the annular ligament of the wrist, and hence pus is rapidly conducted in this way up to, and, if not relieved, into the forearm. There is much difference in the importance of saving the digits. The thumb must be saved at all hazards; middle and ring fingers are comparatively unimportant, and if stiff are apt to be in the way. A stiff forefinger is better than none.—*Can. Lancet.*

Diagnosis of Felons by Transmitted Light.

ADINELL HEWSON, of Philadelphia.

My device is a flattened conical tube of binders' board, with its base five inches in its greater diameter, so trimmed as to make its edges fit closely on my brow, cheeks and upper lip. The tube is of sufficient length to make its apex just about the distance of the range of distinct vision for me. The apex has an orifice of $\frac{1}{8} \times 3$ -16th of an inch. I made this tube of a thin piece of binders' board, 11x18 inches, with cleanly cut edges, by dipping it in boiling water, whereby it was quickly rendered sufficiently pliable to enable me to give it the desired form, rolling it up diagonally from one remote angle to the other, and

maintaining it in that form by twine closely wound round it from apex to base, and left there until it became perfectly dry and hard. Making my tube to fit closely around the contour of my forehead and face, I have all extraneous light excluded then, and the necessity for a blackened interior is sufficiently done away with by the color of the pasteboard used. I have thus, in the simplest contrivance, all the conditions fulfilled for practicing as accurately as possible this method of examining the tissues by transmitted light.

In the instance of examining for suspected felon, the patient's finger is to be brought up to the point of the tube while it is held in the direction of a bright light, either natural, as that from a window, or artificial, as that from a good lamp or gas jet, and then pressing one's face so as to make it fit close in the base. If the apex of the tube appears to be covering healthy tissues of the finger, you can readily perceive the color belonging to them—a bright pinkish red; whereas, if it is on engorged tissues, the color transmitted will be of a more purely red tint, and deepened relatively to that tint according to the engorgement. The existence of such a tint can also be readily determined by contrasting what is apparent with that from the corresponding finger of the other hand.

If the tint perceived, although still reddish, be of a yellow hue, pus has formed in the cellular tissue around, or in the theca of the tendon. If firmer pressure of the finger against the tube removes the reddishness of this tint and leaves it of a positive yellow, the demonstration is complete of the suppuration in the theca of the tendons only, for such pressure cuts off all illumination transmitted laterally through the cellular tissue, and which might have

occasioned that reddishness. Finally, if the tint transmitted under such pressure is of a dirty or opaque yellow color, one may be sure that the bone or its periosteum is the seat of the purulent formation and collection.

VENEREAL DISEASES.

Syphilis Treated with the Elixir Iodo Bromide of Calcium Comp.

Dr. X. T. BATES, New Lebanon, N. Y. (*Jour Mat. Med.*): M. T., aged 25 years, contracted a chancre on the penis some six years since. Consulted me two weeks after venereal indulgence, just as ulcer was making its appearance. The ulcer existed for some time and healed without local applications. Local treatment with the elixir iodo in drachm doses after meals, was administered. Syphilitic erythema and peculiar brown patches on face were early developed. The system was kept under the specific influence of mercury for a period of weeks, when this remedy was relinquished, and the simple elixir iodo resumed and continued for nearly six months. During the interim to date, the young man has enjoyed excellent health, complete immunity from any further trouble in consequence of the venereal contamination, save perchance occasional attacks of pruritus preputialis which may and may not be either the direct or indirect result of the presence of syphilitic virus in the system. The pruritus has been invariably removed by mild emolient washes. In this case sufficient time has elapsed to render the permanence of the cure all but certain.

P. C., aged 22 years, in the early spring of the current year, consulted me for a sore throat and severe muscular pains. Examination elicited the fact that he had already been under treat-

ment for eight months for a chancre and its sequences.

His treatment has consisted of caustic applications to chancre, and the internal use of mercury. The ulcer healed, but the disease itself was in no other way under control. New and harrassing constitutional symptoms seemed almost daily in process of development, and daily increasing in severity, sloughing of throat had already commenced, grey ulcerative patches were quite numerous on palate, and superior and inferior maxillary, active ulcerative affections of different parts of the body were constantly multiplying, and the muscular pains were severe and obstinate. Under influence of frequent topical applications of lunar caustic the sloughing was averted and the ulcerating patches all healed.

Treatment with elixir iodo bromide of calcium comp. with bichloride of mercury was at once instituted and a wash consisting of tinct. ferri chloride was advised for mouth and throat. Constitutional treatment with the iodo and mercury was continued until all symptoms of the disease had disappeared and even then as a preventive measure adhered to for a period of several weeks after a complete cure seemed effected. I have had occasion to see the young man since the treatment was abandoned and he tells me he has experienced no more difficulty.

Treatment of Condylomata or Mucous Tubercles.

R. Hydrarg. bichloridi, gr. v. ; acidi carbolic, gtt. xxx. ; acidi tannici, gr. x. ; aquæ, $\frac{3}{4}$ j.

M. Sig.—Touch the condyloma from time to time with this solution, using a camel's-hair brush.—*Ther. Gazette.*

Treatment of Simple Chancre—Phagedenic.

1. Absolute 'repose, severe regime, laxative drinks, daily baths of two

hours, local baths, poultices with charpie, soaked in infusion of marsh mallow.

2. After complete subsidence of inflammatory symptoms, washes of nitrate of silver 15 grains to distilled water 1 ounce. If this solution appears too irritating, it is diluted.

There are still two local remedies little less beneficial than nitrate of silver. *e. g.*, Potassio tartrate of iron and iodoform. If these fail, it is necessary to fall back on caustics.—*L'Union Medicale.*

Tayuya as an Antisyphilitic.

The tayuya (*Dermophilla pendentica*) is a native of Brazil, and is employed by the indigenous inhabitants of that country as a remedy in syphilis. It was introduced into Europe by an Italian naturalist, Ubicini. The root is the most active part of the plant. In Italy two tinctures are made from it: a strong one, known as the mother tincture, employed in hypodermic injections, in daily doses of a gramme; the other a weaker tincture, consisting of a dilution of the former with three parts of alcohol, is prescribed internally, in daily doses of from six to sixty drops. Analysis has demonstrated the presence of the oxalates of calcium, magnesium, and of iron, a resin, and an uncrystallizable substance supposed to be an alkaloid. The physiological effects of tayuya in small doses resemble those of aloes; in large doses it produces diarrhœa, diaphoresis, and salivation. Clinical experiments have revealed in this substance an antisyphilitic remedy of great value and complete innocuousness.—*Gaz. des Hôp.* and *Gazz. med. de Bahia.*—*Med. Record.*

Mercury Hypodermically in Syphilis.

The use of mercury by hypodermic injections, by Dr. Yourn, under the following formula has done good service:

R. Iodide of mercury, 1 gramme; iodide of potass., 1 gramme; phosphate of soda, tribasic, 2 grammes; distilled water, 50 centim. cubic.

This solution is not coagulated by albumen. Mathles has made 850 injections without accident, twenty-five or thirty being sufficient to restore health.—*Ther. Gazette.*

Late Effects of Hereditary Syphilis on the Bones.

It is rare that a typical case of hereditary bone lesion from syphilitic disease is presented. Such a one was, however, shown at a late meeting of the Manchester, England, Medical Society, by Dr. Bury. The patient was twenty-two. He was quite well till ten years old; then a skin formed over his eyes. He had now symmetrical interstitial keratitis. A little later his mouth and throat became sore; there was now a hole in the right arch of the palate. At the age of eighteen he noticed that his legs were swollen; the tibiae were now greatly thickened, and pieces of bone had come away from the right tibia. There was a large gap in the right side of the frontal bone, from which a sequestrum separated a few months since. Two sinuses near the middle of the forehead also led down to dead bone. The lower fourth of the left femur and the back of the right ulna were thickened. The left upper incisor was absent; the edge of the right upper was ground down.—*Med. & Surg. Reporter.*

Bromine Topically in Chancroids and Chronic Ulcers.

BY J. L. ROBINSON, M. D.

Within the past few months I have had opportunity of testing bromine as a local application to chancroids and chronic ulcers associated with syphilis, as seen in the U. S. Marine Hospital in

this city (Louisville). The following is the formula used: R. Bromine, one part; water, three parts; bromide of potash, q. s. to make a solution. To be applied once daily by means of a mop made of cotton wool.

I subjoin a very brief report of a few of the cases treated.

CASE I.—W. C., colored, chronic ulcer of two years' standing over the anterior middle third of the tibia. First seen April 1st, when the granulations were large, flabby and raised, and the surrounding tissues excessively indurated. Applications of nitrate of silver and sulphate of copper were used daily for nearly a month without effecting any change in the character of the sore. May 1st I applied the bromine solution, and continued it daily. Each application was followed by oakum to the sore and a flannel roller to the limb. In two weeks the granulations came to a level with the surface and were of healthy aspect, the surrounding integuments grew soft and pliant, and cicatrization set in. Some weeks after the ulcer was reduced half its former size and healed rapidly.

CASE II.—C. H., colored, admitted June 30th, having a large ulcer of six months' standing, situated as in Case I, and altogether of a similar character. The bromine, oakum and the roller were at once applied. Improvement was noticeable from the first day, and a speedy cure seems assured.

CASE III.—S. H., white, admitted July 12th, with an ulcer of both legs just above the internal malleoli. Much the same appearance as in cases just described. The same treatment effected almost at once the most striking change, and in four weeks the patient was discharged cured.

CASE IV.—A. L., colored, admitted July 2d, ulcer four square inches in size, of six months' standing, situated just

above the ankle on the inner side of the right leg, cup-shaped, covered with a greenish slough, and made offensive by a fetid ichorous discharge. The bromine, etc., quickly reduced the ulcer two-thirds in size, besides converting it in all respects into a healthy sore, which gives promise of uninterrupted and quick cure.

CASE V.—J. L., white, admitted Aug. 2d, with a large indolent ulcer of two years' standing, immediately above the external malleolus of the right leg. Numerous smaller ulcers existed in the region of both ankles. Bromine, oakum and the flannel roller accomplished much the same results as in the previous cases.

Fifteen-grain doses of the iodide of potassium, given three times daily, made up the constitutional treatment in the foregoing cases, except in Case I, where cod-liver oil was deemed advisable.

I have also used the bromine in several cases where, after the operation of circumcision, inoculation of the entire raw surface had occurred, with equally good, I might even say with better results than in the leg-ulcers.—*Am. Practitioner*.

Chloral Hydrat. in Gonorrhœa.

In the *Bull. Gen. de Therapeutique*, 1880, Dr. PASQUA reports four cases of gonorrhœa in its early stage treated with a chloral solution:

R̄. Chloral hydrati, gr. vj.; aquæ rosæ, fl. ʒ j. M.

Two urethral injections daily were used, the fluid being retained a few minutes in the urethra. Improvement began in four or five days, and the discharge ceased in eight or ten days. No unpleasant sequelæ appeared.—*Med. and Surg. Reporter*.

Permanganate Potash in Gonorrhœa.

Dr. BURGEIS (*L'Union Medicale*) claims good results from the following

injection in gonorrhœa: Permanganate of potash, three grains; distilled water, a pint and a quarter. Three injections a day after acute stage is passed. Treatment to be continued for fifteen days.

In Spermatorrhœa.

R̄. Camphoræ, grs. 5; ext. belladonnæ gr. ʒ; ext. conii, grs. iv.; spts. rectificati sufficient to make two pills. Sig. To be taken every night at bed-time.—*Ibid.*

DISEASES OF THE EYE AND EAR.

Autumnal Conjunctivitis.

Dr. HENRY S. SCHELL, of Philadelphia (*Med. and Surg. Rep.*):

After giving the usual symptoms, Dr. Schell concludes as follows in regard to the important differences between autumnal and catarrhal conjunctivitis, to which we add his treatment for the former. The distinction may ordinarily be made by taking into consideration the time of year when the malady occurs, the paroxysms of intense itching, in and about the eyes which accompany the disease, and the nasal catarrh which is so frequently present.

Treatment.—So long as the acute symptoms persist, the greatest relief will be obtained from the constant application of infusion of slippery elm bark or sassafras pith to the conjunctiva, with the use of cosmoline or vaseline to the eyelids. If the latter become excoriated, oxide of zinc in the proportion of three grains to the drachm may be added to the fatty matter. If the itching is intense, camphor water may be added to the demulcent infusion, in the proportion of one part of the former to four of the latter.

After the paroxysms of itching have decreased in frequency, borax may be

cautiously added to the demulcent, at first in the strength of two, afterward of four, and finally of ten grains, to the fluid ounce. But its use should be desisted from if it provokes a return of the itching. After the sensitiveness of the parts has subsided a collyrium of tannin, eight grains to the fluid ounce, applied three times a day, will usually suffice for the cure. If the disorder continues, however, after the occurrence of frost, it will often be necessary to apply a four-grain solution of nitrate of silver to the inner surface of the lids.

During the whole course of the affection, quinine should be administered in tonic doses. Bromide of potassium should also be given at night, in quantities sufficient (ten to sixty grains) to allay irritability. If the patient is troubled with occasional alternations of heat and chilliness, or is very sensitive to currents of air, ten drops of the tincture of belladonna may be added to each dose of quinine.

The Use of Hot Water in the Local Treatment of Diseases of the Eye.

DR. LEARTUS CONNOR (*Amer. Jour. Med. Sciences*) speaks very highly of the frequent local application of hot water to the eye in cases of acute conjunctivitis and blepharitis, and also in chronic hyperemia, granular inflammations, iritis, and corneal affections, in which he has used it with great success. The water must be as hot as the patient can comfortably bear with his hand. The patient leans over the basin and throws the water against the eye for a few minutes three or twelve times a day, according to the case.—*Chic. Med. News.*

DISEASES OF THE SKIN.

Cutaneous Eruptions caused by the Use of Certain Medicines.

(*Giorn. It. dei Malatt. Vener. e del Pelle*) ANSPITZ, in his valuable "System der Hautkrankheiten," gives the following list of eruptions liable to follow the use of certain remedies:

Quinine.—(a) Scarlatinous erythema, (b) morbillous papular erythema, (c) hæmorrhagia and purpura, (d) wheals, œdema, pruritus.

Cinchona, Belladonna, Strychnine, and Stramonium.—Manifestations like papulæ sudorales.

Digitalis.—Erythema after a few days' use.

Aconite.—Vesicular exanthema.

Santonine.—Vesicles, wheals.

Rhus Venenata and Toxicodendron.—Vesicular eruption.

Opium and Morphine.—Erythema, papular eruption, with much desquamation and pruritus.

Pilocarpin (?).—Augmentation of the perspiration.

Phosphorus.—Purpura.

Phosphoric Acid.—Bullous eruption.

Mercury (internally).—Erythema, eczema.

Arsenic.—Erythema and papules, eczema.

Carbolic Acid.—Erythema, vesicles, or wheals.

Salicylic Acid.—Purpura, vesicles with laryngeal catarrh, wheals.

Chloral Hydrate.—Erythema (well colored), pruritus, desquamation, purpura, and petechiæ, eczema with crust and scab.

Balsam Copaiba, Cubebs, Turpentine.—Vesicles, erythema, eczema.

Cod-Liver Oil.—Acne.

Iodide of Potash.—Papules, vesicles and bullæ, pustules and erythema, eczema, ecchymosis, and purpura.

Bromide of Potassium.—Papules and pustules, deep tubercles and ecchymosis, vesicles, ulcers. — *Virginia Medical Monthly*.

Tinea Versicolor.

Prof. DUHRING (*Med. and Surg. Reporter*):

A young man, about twenty-two years of age. The disease is situated on the back, from the neck to the lumbar region, and on the front of the body, from the clavicle to the umbilicus. It is scattered over the regions indicated, in the form of yellowish, irregularly-shaped areas. These patches, especially those of recent origin, have a sharply-defined border, and present a striking contrast when compared with the healthy skin. There is scarcely any elevation, but the patches are covered with the peculiar characteristic furfureous scaling; which can easily be scraped off with the finger nail.

The cause of the disease is the presence of a vegetable parasite, called microsporon furfur, which can readily be detected in the scales by means of the microscope. The parasite exists in the state of mycelium and spores, and is almost exclusively confined to the upper layer of the epidermis.

The disease is easily recognized, yet it may be overlooked; and I have seen it often absurdly mistaken and treated for jaundice, on account of the yellow discoloration; indeed, it was at one time called liver-spot disease, the patches being known as liver spots. The disease is thoroughly curable, and the treatment is very simple; all that is required is extreme cleanliness and the assiduous use of some parasiticide.

I think that the best results are obtained with sulphurous acid; the patient will, therefore, be directed to use a lotion composed of one part of sul-

phurous acid, diluted with two or four parts of water, after having taken a bath and rubbing the affected parts well with sapo viridis. The parts should be well washed before each application, and the lotion should be applied night and morning.

Corrosive sublimate, in form of lotion, one or two grains to the ounce, may be used with good effect.

Tincture of veratrum viride is likewise good. Unless the treatment is thorough, relapses are very apt to occur.

Tinea Tonsurans.

(Clinic of Prof. DUHRING, *Ibid*):

This little boy had been brought to the clinic by one of the students. He comes from a neighboring town, with a disease of the scalp. The first thing that we notice is that his hair has been clipped. He is about eight years old, fairly nourished, and has light hair; he is spare and has the general appearance of a strumous disposition. He probably cares little for meats, or fats of any kind; he says that he never eats fatty food.

Examining the disease, we observe that it occupies the greater part of the scalp, in the form of a good deal of scaling, which has been plastered down by ointments; in addition, we see signs of the disease in the form of irregularly-rounded patches, which are somewhat bald. Over the occipital region we have the outline of quite large patches, which have coalesced. The disease, from its appearance, has probably lasted for six weeks or longer. He says it started three months ago. Looking more carefully, we see that the hairs are partially destroyed on the patches. In addition to the patches being bald, the orifices of the follicles are puckered, the skin looking like that of a plucked goose. This

appearance is pathognomonic of ring-worm of the scalp—*tinea tonsurans*.

Examining the disease more closely, we see a number of stumpy hairs, which can be easily plucked out. Placing these hairs under the microscope, we shall observe that they are thoroughly invaded by the parasite. The patches of baldness are more or less irregular in outline, and in the parietal region we observe the hairs thoroughly "nibbled off" by the parasite.

The diseases with which we are likely to confound it are seborrhœa and squamous eczema. Considering the partial baldness of the patches, the stumpy, loose hairs, and the presence of the parasite, there is no difficulty in diagnosing the case from eczema. From seborrhœa it can be diagnosed by the fact that the hairs are nibbled off and destroyed, while in seborrhœa atrophy occurs. Again, in seborrhœa we have simple epithelial and fatty degenerated scales; here we have not only the scales, but also the hairs invaded by the parasite. The diagnostic aid which the microscope gives us is often of great importance, and no one can work in this branch of medicine without its valuable assistance.

In all cases there are two lines of treatment to be observed: depilation, or the extraction of the hairs, and the use of a parasiticide; being careful, however, not to use too strong ointments or solutions, lest you cause undue inflammation. The disease is treated somewhat differently, according as it occurs on small or large areas of surface, in the latter case being more difficult to cure.

As parasiticides, the sulphur preparations are all valuable, in the form either of ointments or solutions. In this case we cannot do better than order sulphurous acid. Before applying this, we

will direct the scalp to be cleaned with warm water and soft soap twice a day, after which the acid is to be used by dabbing it on with a soft rag, it being diluted at first with two or four parts of water, increasing the strength until it is used pure. If the skin, during our treatment, becomes dry, we may combine with other treatment the use of cosmoline. Besides this, depilation must be practiced, the loose hairs being removed by the forceps.

Another remedy which is sometimes used is corrosive sublimate, it being employed of the strength of from one to five grains to the ounce of water or alcohol. It is, however, liable to be absorbed and to produce constitutional symptoms, especially if applied to large surfaces. Such cases have been reported, and one case where the use of a ten-grain solution was followed by death. I must say, however, that I have never seen any cases of this kind.

Treatment of Skin Affections by Naphthol.

Recent experiments have been made in Vienna by Professor KAPOSÍ, according to which naphthol has been brought prominently forward as a cure for skin diseases. It appears that the drug acts in a similar manner to tar, of which it is a product, but has no odor, or almost none, and is quite colorless when used in the form of ointment. For scabies an ointment was used of 10 to 15 per cent. strength, and it is asserted that it not only kills the *acarus*, but that it simultaneously cures the secondary eczema depending upon the parasite. In psoriasis it has also been found very beneficial, neither staining the skin nor the hair.—*Wien. Med. Wochen.—Chic. Med. Review.*

**Lupus Exedens Treated Successfully by
Creosote and Calomel.**

Dr. A. VAN DERVEER (*Med. Annals*): P. S., aged 65. No trace of disease of ulcerative nature in family. About fifteen years previous, patient first noticed a small wart, about the size of the head of a pin, in front of left ear, which remained about the same for a period of five years. Then it began to get a little sore, and if scratched would bleed, a scab forming afterwards. He also noticed then that a small ulcer was progressing, which increased and spread downwards and then towards the eye, the ulcer healing and crusting over in its track. The character of the sore was, in form, irregular, without discharge, up to this time, and painless, being accompanied, however, with an intense itching sensation, so great sometimes that the patient could scarcely control himself. The disease advanced, surrounded the eye, implicated the lids, and crept on over the left side of the nose, down to the alæ, and a portion on the right side. About three months before coming into hospital the ulcer began to discharge a thin purulent matter very profusely, so as to require, at times, redressing every hour or less. When admitted, the disease covered almost entirely the upper half of left side of face. At first creosote alone was applied, then the di-chlor-acetic acid was used with some benefit. Then applications were made of creosote and calomel, and from the first use of it the ulcer began to improve. The method of using it was to take a camel's hair pencil, dip it first in the creosote, then in a dry powder of calomel, applying it to the edges and where depressions existed, the brush, with a twirling motion, dislodging and removing the cells. By this treatment, the surface glazed over

with healthy skin, its size diminished, and at present there only remains a small portion of the disease over the eyelids, without any indications of its returning or spreading again.

Scaly Eczema.

Dr. EDWARD SHARP, of Salem, N. J. (*Med. Bulletin*), recommends the following combination:

R. Adipis, ℥. j.; lac. sulphuris ℥ iv.; ung. hydr. ox. rub., 3 x.; ol. gaultheriæ, ℥ j. Mix the sulphur gradually with the red mercurial ointment, adding the lard from time to time, as the mixture requires dilution; and when all the lard and mercurial ointment are thoroughly mixed with the sulphur, add and intermingle the oil of wintergreen.

Perchloride of Iron.

CASARINI advocates this remedy in certain skin affections, and concludes: (1) that the perchloride of iron externally is the most efficacious remedy against purpura hemorrhagica and purpura simplex; (2) that it is very useful in the cachectic chloro-anæmic condition, which often accompany certain affections of the skin, as rupia, ecthyma, impetigo; (3) externally this remedy exercises a prompt and favorable influence over ulcers dependent upon scrofula and constitutional syphilis; (4) employed as an ointment, it is an energetic and efficacious modifying agent in desquamating affections of the skin, as psoriasis; (5) it may be used in the form of lotions with 2-3 parts of water, or as an ointment containing 1-2-3 grm. of the perchloride to 30 of lard.

Casarini has used the remedy in psoriasis in the proportion of 10 grm. to 30 of lard or glycerine, with satisfactory results, especially when glycerine was employed.—*Riv. Clin. di Bologna*.—*Med. Record*.

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Case of Fracture, with Remarks.

Dr. HENRY J. REYNOLDS (*Detroit Clinic*): On October 15th, 1878, was called to see a gentleman æt. 70, who had been an invalid for a number of years, having been stricken with paralysis once or twice, from which he had never fully recovered, leaving him unable to get around without a cane in one or both hands. Patient's mental condition was also bad, and had been for a number of years very much below par, rendering him quite imbecile.

I found he had fallen and fractured both bones of the leg at the junction of the middle with the lower third. After reducing the fracture and leaving it in wooden splints for six days, I removed the dressing and secured the limb in a plaster of Paris bandage. Owing to general breaking down and wearing out patient gradually failed, and died on Nov. 10th, between three and four weeks from time of injury.

The particularly interesting features in this case were that owing to the mental condition of the patient, he had no regard for the broken member whatever, but would toss himself about the bed in all shapes, and even get right out of the bed and use the leg pretty much as if nothing had happened to it whatever. His wife, a lady about the same age, living in the house alone with him, that she should not be obliged to remain constantly with him, strapped him to the bed, but all to no avail; he was bound to go right along as if nothing had hap-

pened, and did so most of the time. Under these circumstances, together with the frail condition of patient's system and the short duration of time from date of injury to time of death, I had little or no hopes of obtaining any union, or at least, if any union, great displacement; but, to my surprise, on removing the plaster of Paris splint after death, I found a firm, solid, bony union with perfect apposition. Union in this case took place in a little over three weeks from date of injury, or a little over two from the application of the plaster splint.

The above case, I think, illustrates clearly that any great force or firm pressure in such cases after the fractured bones are brought into perfect apposition is not really required, if only gentle, uniform and equal support be given to all the tissues surrounding the fractured bone for a certain distance above and below the point of injury. In almost all of the fractures of the long bones I think the plaster of Paris splint properly applied, with the right amount of uniform pressure, renders displacement almost impossible.

I might say one word more in this connection, that I think the young surgeon is liable to bandage too tightly in applying splints to a fracture, thereby impeding the process of repair and producing swelling below, sloughing, etc.

Insanity Resulting from Depressed Fracture of the Skull Cured by Trephining.

A patient of Dr. Daniel Mollière, suffering from traumatic insanity resulting from a depressed fracture on the left

parietal region, presented only vague general symptoms. There was no localized anæsthesia, no paralysis, and no febrile movement. Dr. Mollière, having diagnosed traumatic insanity due to cerebral irritation from spiculæ of the depressed bone, removed six fragments of bone by means of the trephine, the screw-elevator, a gauge, and a mallet, thus denuding the dura mater. The wound, which was treated by Lister's method, healed in a month. The patient quickly recovered his reason, but evinced a peculiar irritability, and a loquacity comparable to that of slightly intoxicated persons. The symptoms disappeared, however, after a few months, and the patient's functions were thenceforth normally performed. —*Annales et Bulletin de la Société de Médecine de Gand.*

Fracture of the Internal Extremity of the Clavicle.

Prof. GUYON (*La France Médicale*): M., male, æt. 39, in good general health, complained of inability to use right upper extremity. He had been struck on the external part of the right shoulder by a window-sash falling from a considerable height, two days previous to admission. The pain was then very intense over the whole region of the shoulder and inferior part of the breast, and was increased by the least movement of the arm. On presentation, the position was remarkable: the arm, lightly carried behind him, was drawn very near the trunk, the patient avoiding carefully the least movement. The head, a little inclined towards the fractured clavicle, was also inclined forward. The least alteration in these positions awakened great pain. Upon inspection, the region of the right clavicle presented a limited swelling, which occupied the whole of the internal half;

a large ecchymosis existed about the same points, little marked about the region of the neck, but very extensive and diffused upon the superior part of the thorax. Upon the external part of the shoulder, on a level with the summit of the acromion, there was a slight abrasion, which was the point upon which the blow was received. Upon exploration by palpation, a fine *crépitation amidonnée* could be produced under slight pressure over nearly the whole ecchymosed region. More deeply we discovered an osseous tumor lying along the line of the clavicle, and which was continuous outward, diminishing progressively. Inwardly, on the contrary, was a sudden depression, a projection which did not correspond to the intra-clavicular space, but situated upon a point which could be traced a centimetre outward. The mensuration of the two clavicles gave the same length. Movement of the upper extremity produced a sharp pain on a level of the internal clavicular region. The abduction and elevation of the arm were much less painful than the other movements, and the size of the tumor was unaffected. When, however, the arm was carried forward with abduction, the tumor was considerably reduced, but the pain at the same time was very severe.

The diagnosis was not very clear: we had some of the symptoms of the fracture of the internal portion of the clavicle described by M. Delens. We had the fusiform swelling, the absence of localized crepitation, and the position; but there was no shortening, the reduction was easy, if not complete, the tumor was attached, it is true, to the external part, but inward it ceased suddenly, and we could recognize by palpation an abrupt projection without irregularities which might readily be mistaken for the artic-

ular extremity of the clavicle. The diagnosis of luxation forward and upward was made with some reservation, but the progress of the case during the following days did not bear out this diagnosis. The ecchymosis was limited, and the whole crepitation disappeared. The osseous projection augmented quite rapidly, especially at the expense of the inferior aspect of the bone; its vertical diameter was, at the end of four days, three finger-breadths, and the fusiform swelling persisted. The projection became less and less defined and lost itself in the general swelling. The movements of the arm forward and inward no longer produced reduction, but affected the size of the tumor only a little. Eight days later the patient desired to leave the hospital. The pains were then much less severe, but all spontaneous movement was still impossible; the clavicular tumor made a considerable projection under the skin, and had then the dimensions of a mandarin orange. Six weeks later the patient returned to the hospital. The movements were yet very difficult and limited. The swelling in the region of the shoulder had almost entirely disappeared, and it was quite evident that the sterno-clavicular articulation was intact. There was, however, commencing upon it, a growth of callus large and irregular surrounding the inferior part about a centimetre outward, and at that time the mensuration of the fractured bone seemed to indicate a shortening of some millimetres.—*Med. Times.*

Rare Dislocation of the Upper Extremity of Ulna inward, the Radius remaining in its Normal Position.

DR. GEORGE WRIGHT (*Detroit Clinic*) demonstrator of anatomy, etc., Toronto School of Medicine, reports this rare form of dislocation as occurring in a girl, æt. nine years, the result of a fall on the

elbow. For various reasons the attempt at reduction did not take place until twenty-eight days after the accident. At this time, on careful examination by several members of the hospital staff, it was agreed that there was dislocation of the olecranon process inwards upon the condyle of the humerus, with the head of the radius in its normal position. No weight could be carried owing to rotation inwards when arm was extended.

One hour and a half's faithful attempt at reduction failed. The doctor explains as a reason of failure that the patient had received, when two years of age, an injury to this same elbow, causing separation of the epiphysis, the external condyle being broken off, thereby favoring the inward displacement.—*Canadian Journal of Medical Science.*

Successful reduction, after four months' malposition, of a dislocated third cervical vertebra, causing various serious nervous symptoms.

Dr. LANDON CARTER GRAY, of Brooklyn (*Annals of Anat. & Surg.*), says:

A lad 15 years old, was brought to me. Four months before he had attempted to turn a somersault, and had fallen upon his head. There was neither loss of consciousness at the time, nor any untoward symptom other than the appearance of a small projection upon the back of the neck. The next morning he experienced some slight difficulty in swallowing, which steadily increased, although varying in degree from day to day. About thirteen weeks after the accident the bladder became distinctly, though not markedly, parietic. About fourteen weeks after, the patient became sensible of a numbness in the left arm. Three days before coming to me, the left upper and lower extremities became powerless, although, singular to say, this lower extremity had not shown any sub-

jective alteration of sensation except a slight itchiness. During the week previous to his visit a slight numbness had appeared in the right leg. At this first examination I found the left upper extremity almost completely paralyzed in motion, the left lower extremity somewhat less so, both these extremities moderately paralyzed in the sense of touch, and the left side of the face paretic. The left upper extremity was decidedly fuller than the other, without, however, presenting any œdema or unusual vascularity. There was occasionally a quick, sharp tremor of the whole body, which came on only while he was standing. The tendon reflex of each quadriceps extensor was greatly exaggerated; but there had not been at any time any symptoms of hasty micturition. Over the region of the third cervical vertebra, there was on the back of the neck a projection about as large as a pigeon's egg. Pressure upon it produced some pain around the point of pressure, but none was felt at the front or side of the neck. The spinous process of the third cervical vertebra was deviated markedly to the right. Inserting the finger into the mouth, horizontally backward on a level with the upper surface of the tongue, a distinct depression could be felt in the posterior pharyngeal wall, corresponding to the third cervical vertebra. The attitude of the head was peculiar. The right ear was strongly inclined to the right, the chin directed to the left, but the point of the chin was not elevated. The right sterno-cleido-mastoid was prominent and tense. The point of the left shoulder was drawn up, the acromion process of the scapula being approximated to the median line of the body, and the inferior angle being thus thrown out.

The difficulty of swallowing had become so great that the boy was fed on

soft and liquid food, and at certain times even this was troublesome; the nervous symptoms were progressing at an ominous pace; nothing but a restoration of the bone to its proper place offered any hope of saving life; and if the reduction were prevented by the callus of a former fracture of the spinous process, no harm could be done by the attempt.

In making reduction counter-extension was made by means of folded sheets laid over each shoulder and then brought across the back and shoulder to the opposite side, where the ends of each were placed in charge of an assistant. A gag was used to separate the jaws. The boy was laid flat upon his back on the table, and etherized until all his muscles were well relaxed. Supporting the head by one hand upon the occiput and the other upon the brow, both my hands being covered by those of an assistant, and counter-extension being firmly maintained, I made extension steadily upward to what I deemed a proper degree, and then slowly and cautiously rotated the head from left to right. It was necessary to make this rotation three separate times before the bone went into place, each rotation, however, effecting evident improvement, although no tendinous snap was heard at any time.

On returning to the house about four hours after the reduction, I was gratified at finding the boy bright and cheerful, having no longer any difficulty in deglutition—he had drunk heartily of milk, which he had hitherto taken only by the spoonful—able to lift his hand readily to the top of the head, much improved in motor control of the left lower extremity, and free from numbness anywhere. The patient was not permitted to rise from the table for upwards of three weeks. During this period the head was kept between the prongs of a

photographer's head-rest, which permitted of sufficient lateral motion to render the position endurable, and at night a watch was kept to see that the head was not displaced from this support. At the end of this time he was allowed to assume a sitting posture for a couple of days, and then to go about the room. I now noticed that the spinous process of the third cervical vertebra began to deviate again from the line of its fellows, but only to a very slight degree, and a faint depression could again be felt corresponding to the vertebral body; no nervous symptoms, however, were manifested. I was reluctant to interfere again unless it became absolutely necessary, and I contented myself with enjoining great caution and deliberation in the movements, as well as confinement to the house. Notwithstanding these directions, the patient, after a week of this irksome life, started out one morning and walked about for several hours. The next day I found a distinct, though not very marked, displacement of the vertebra. I immediately determined to run no risk of pressure upon the cord, and accordingly brought the table and the photographer's head-rest into play as before, and kept him thus until I again reduced the bone a few days after. The reduction was easily made, and the bone went into place with a sharp ligamentous snap. Two weeks more in the supine posture and the patient got up, cautiously at first, and has had no further trouble.

Senile Osteomalacia.

(*Lyon Médical*). True, osteomalacia may be developed in the aged as in adults. The affection may show itself beginning at an advanced age—at seventy years or beyond; it may be traced back to the adult age, and the disease has followed a slow and progressive

evolution up to the moment when an acute exacerbation takes place, which terminates the scene. Ordinarily, the disease begins with pains located more particularly in the vertebral column, the ribs, the sternum, etc.; it is only at a later period that they invade the pelvis and, at times, the lower extremities. These pains are vague, ill-defined, at times very violent; they occur especially when the patient would make some movement or muscular effort; they are provoked by walking. These painful phenomena, which may exist by themselves for a long time before deformity, ought to attract the clinician's attention.

Osseous deformities, occurring in people of advanced age, seem, like the pains, to be localized by preference at certain points; these are the vertebræ, which generally are the first to become flat, leading to a curving of the body and a dorsal arching with deformity of the thorax. The bones of the lower extremities may undergo a certain degree of softening, but no such deformity has been observed here as occurs in the osteomalacia of adults.

Regarding the causation, nothing special has been noted in the aged.

Anatomical examinations demonstrate that we have to deal with a true osteomalacia. Zones of decalcification are formed with the characters met with in the adult; the lesions of the osseous marrow are, perhaps, slightly modified, by reason of the changes which it undergoes in the aged. The author (M. Demange) has not found waxy osteomalacia; the brittle form (*ostéomalacie fracturante*) has alone been observed. This is doubtless because the patients have not survived a sufficient time.

The progress of the affection is that of marantic diseases; the patient becomes enfeebled, he has an excessive

jective alteration of sensation except a slight itchiness. During the week previous to his visit a slight numbness had appeared in the right leg. At this first examination I found the left upper extremity almost completely paralyzed in motion, the left lower extremity somewhat less so, both these extremities moderately paralyzed in the sense of touch, and the left side of the face paretic. The left upper extremity was decidedly fuller than the other, without, however, presenting any œdema or unusual vascularity. There was occasionally a quick, sharp tremor of the whole body, which came on only while he was standing. The tendon reflex of each quadriceps extensor was greatly exaggerated; but there had not been at any time any symptoms of hasty micturition. Over the region of the third cervical vertebra, there was on the back of the neck a projection about as large as a pigeon's egg. Pressure upon it produced some pain around the point of pressure, but none was felt at the front or side of the neck. The spinous process of the third cervical vertebra was deviated markedly to the right. Inserting the finger into the mouth, horizontally backward on a level with the upper surface of the tongue, a distinct depression could be felt in the posterior pharyngeal wall, corresponding to the third cervical vertebra. The attitude of the head was peculiar. The right ear was strongly inclined to the right, the chin directed to the left, but the point of the chin was not elevated. The right sterno-cleido-mastoid was prominent and tense. The point of the left shoulder was drawn up, the acromion process of the scapula being approximated to the median line of the body, and the inferior angle being thus thrown out.

The difficulty of swallowing had become so great that the boy was fed on

soft and liquid food, and at certain times even this was troublesome; the nervous symptoms were progressing at an ominous pace; nothing but a restoration of the bone to its proper place offered any hope of saving life; and if the reduction were prevented by the callus of a former fracture of the spinous process, no harm could be done by the attempt.

In making reduction counter-extension was made by means of folded sheets laid over each shoulder and then brought across the back and shoulder to the opposite side, where the ends of each were placed in charge of an assistant. A gag was used to separate the jaws. The boy was laid flat upon his back on the table, and etherized until all his muscles were well relaxed. Supporting the head by one hand upon the occiput and the other upon the brow, both my hands being covered by those of an assistant, and counter-extension being firmly maintained, I made extension steadily upward to what I deemed a proper degree, and then slowly and cautiously rotated the head from left to right. It was necessary to make this rotation three separate times before the bone went into place, each rotation, however, effecting evident improvement, although no tendinous snap was heard at any time.

On returning to the house about four hours after the reduction, I was gratified at finding the boy bright and cheerful, having no longer any difficulty in deglutition—he had drunk heartily of milk, which he had hitherto taken only by the spoonful—able to lift his hand readily to the top of the head, much improved in motor control of the left lower extremity, and free from numbness anywhere. The patient was not permitted to rise from the table for upwards of three weeks. During this period the head was kept between the prongs of a

photographer's head-rest, which permitted of sufficient lateral motion to render the position endurable, and at night a watch was kept to see that the head was not displaced from this support. At the end of this time he was allowed to assume a sitting posture for a couple of days, and then to go about the room. I now noticed that the spinous process of the third cervical vertebra began to deviate again from the line of its fellows, but only to a very slight degree, and a faint depression could again be felt corresponding to the vertebral body; no nervous symptoms, however, were manifested. I was reluctant to interfere again unless it became absolutely necessary, and I contented myself with enjoining great caution and deliberation in the movements, as well as confinement to the house. Notwithstanding these directions, the patient, after a week of this irksome life, started out one morning and walked about for several hours. The next day I found a distinct, though not very marked, displacement of the vertebra. I immediately determined to run no risk of pressure upon the cord, and accordingly brought the table and the photographer's head-rest into play as before, and kept him thus until I again reduced the bone a few days after. The reduction was easily made, and the bone went into place with a sharp ligamentous snap. Two weeks more in the supine posture and the patient got up, cautiously at first, and has had no further trouble.

Senile Osteomalacia.

(*Lyon Médical*), True, osteomalacia may be developed in the aged as in adults. The affection may show itself beginning at an advanced age—at seventy years or beyond; it may be traced back to the adult age, and the disease has followed a slow and progressive

evolution up to the moment when an acute exacerbation takes place, which terminates the scene. Ordinarily, the disease begins with pains located more particularly in the vertebral column, the ribs, the sternum, etc.; it is only at a later period that they invade the pelvis and, at times, the lower extremities. These pains are vague, ill-defined, at times very violent; they occur especially when the patient would make some movement or muscular effort; they are provoked by walking. These painful phenomena, which may exist by themselves for a long time before deformity, ought to attract the clinician's attention.

Osseous deformities, occurring in people of advanced age, seem, like the pains, to be localized by preference at certain points; these are the vertebræ, which generally are the first to become flat, leading to a curving of the body and a dorsal arching with deformity of the thorax. The bones of the lower extremities may undergo a certain degree of softening, but no such deformity has been observed here as occurs in the osteomalacia of adults.

Regarding the causation, nothing special has been noted in the aged.

Anatomical examinations demonstrate that we have to deal with a true osteomalacia. Zones of decalcification are formed with the characters met with in the adult; the lesions of the osseous marrow are, perhaps, slightly modified, by reason of the changes which it undergoes in the aged. The author (M. Demange) has not found waxy osteomalacia; the brittle form (*ostéomalacie fracturante*) has alone been observed. This is doubtless because the patients have not survived a sufficient time.

The progress of the affection is that of marantic diseases; the patient becomes enfeebled, he has an excessive

fear of being moved; the slightest pressure over the osseous projections is painful; walking becomes impossible, while there is neither paralysis nor contractures; and finally he remains in bed, legs extended, the body doubled upon itself, and the head raised high upon a stack of pillows. For a long time digestion goes on regularly; then diarrhoea supervenes and carries off the patient in marasmus, if a bronchitis or a pneumonia does not intervene to hasten the fatal issue.—*Revue de Médecine.—St. Louis Clin. Record.*

Exostoses of the Popliteal Region.

Dr. THOS. M. MARKOE (*Med. Record.*)

Henry F. W.—, seventeen years of age, has a hard lump on the inner and lower side of the popliteal space on the right side, which he said he had discovered about four years previously, when it was extremely small. It slowly and steadily increased during the past three years, but during the last year, and particularly during the last six months, it has increased at a much more rapid rate. A firm, hard tumor was found projecting from the posterior and inner surface of the head of the tibia, about two inches below its articular extremity. It seemed to be nearly the size of the closed fist, and occupied and filled all the lower and inner portion of the popliteal space. The surface was smooth, but presented a number of knobs and irregularities which could be distinctly felt through the integuments. It was painless on pressure, and perfectly unyielding to any amount of force. It had already gained such a size as to interfere with complete flexion of the leg, particularly in walking. Pulsation good in all the arteries below. No œdema. There could be but little ground for hesitation as to the diagnosis of exostosis, but the knobbed and irre-

gular surface suggested a predominance of cartilage.

The operation for its removal was performed as follows:

A long, longitudinal incision was made over the centre of the tumor, and exposed a free, serous-looking, shining surface, evidently cartilaginous, and from all the exposed faces the tissues could be separated with the greatest facility. In fact, it seemed as if there was no connection whatever with the surrounding tissues over the largest part of the surface of the tumor, except by a few fine, glistening, white fibres, which passed loosely from one to the other. The tumor was traversed by a few healthy muscular fibres, which were easily slipped aside over the smooth surface. Some few deeper muscular layers were divided to give more easy access to the point of origin of the growth. The artery was found skirting the base of the tumor on its outer side, pushed somewhat from its normal course, and some care was necessary in order to avoid it. The base of attachment was found to be comparatively small, the mass of the tumor overhanging it nearly equally on all sides. A chain-saw was passed round this narrow pedicle, and the mass removed. From the deep situation of the pedicle at the point where it sprang from the bone, the chain-saw could not be worked parallel with the surface of the tibia, and, accordingly, it sawed its way out obliquely, leaving the pedicle still quite prominent from the bone. With some considerable difficulty, owing to its depth from the surface, this prominence was removed by chisel and gouge, and then it could be seen that the point of outgrowth of the tumor from the bone did not occupy a space of more than about a square inch. The operation was done under full Listerian precautions. Some suppuration followed,

and rather a slow healing by granulation, but no important accident happened during the cure.—*Med. Record.*

VENEREAL DISEASES.

Mercury in the Treatment of Syphilis.

Prof. GEO. HENRY FOX, A.M., M.D.
(*Med. Record*):

First.—In the treatment of syphilis, mercury is naturally the most valuable curative agent of which we have any knowledge. The positive results which follow its employment are such as to convince any competent observer as to its efficacy.

Second.—Mercury is an overrated remedy. The fact that a remedy will do much is no sign that it will accomplish everything that may be desired of it. It will lessen the manifestations and shorten the natural course of syphilis in most cases, but it will not always produce a speedy and beneficial effect, as most physicians are inclined to believe. Some of the worst cases of syphilis in my practice have occurred in patients to whom I gave mercury for one or two years.

Third.—If the profession generally were more strongly impressed with the great value of hygienic measures in the treatment of syphilis, and were less inclined to confide solely in the specific action of mercury, I am convinced that patients would receive a far greater amount of benefit. Remedial agents often acquire a fictitious value by reason of the fact that patients improve during their administration. We know that mercury is not inert, and have ample proof that it can and does accomplish a great deal. The improvement which takes place in our syphilitic patients when treated is not wholly the effect of mercury. It is due in great measure to the vis medicatrix.

Fourth.—Mercury is not essential to the cure of syphilis. This disease, like other erythemas, tends to run its course. It may be severe, and, in that instance, terminates fatally. In the majority of cases it is a far less malignant disease than it is supposed to be. If the patient is of sound constitution and the infection is mild, it usually runs its course without injuring the health of the patient. It may be said that such patients will suffer more from severe lesions in later years. I believe that these patients are as thoroughly cured as though they had taken mercury. I have seen hale men of advanced years who have had syphilis in their younger days and have received no specific treatment, so that I cannot believe that mercury is essential to the cure of the disease.

Fifth.—The internal administration of mercury is preferable to the inunction, vapor-baths, etc.; in every case for the cure of constitutional disease. A somewhat extended trial of mercurial inunction has led me to abandon it. It is but just for me to say that my experience with the vapor-baths and hypodermic injections has been very limited. They possess no advantages over the method of internal treatment which I can recommend, nor can they claim the merit of simplicity.

Sixth.—The dose of mercury usually given to syphilitic patients is unnecessarily large. From the time when the beneficial effect of mercury was estimated by the pints of saliva which dribbled from the patient's mouth, there has been a sudden tendency toward diminution of the dosage of this drug. I believe that in the vast majority of cases the very best effects on syphilis may be obtained by the employment of doses which will not incur the slightest danger of salivation. I have no faith in the administration of doses upon the ho-

mœopathic principle. The daily dose of one-half to one grain of the biniodide will do more good than two to three grains. Regarding the choice between metallic mercury and the numerous salts, I am not prepared to speak. The protiodide given in the form of trituration will not cause gastric disturbance. In the late stages of syphilis I have followed the custom of changing from the green to the red iodide. In my own experience, I have never observed any benefits result from the combination of various salts, as recommended by Bumstead, or by the frequent change from one preparation to another.

Seventh.—The duration of mercurial treatment should vary according to the character of the case. There are cases of mild and cases of severe syphilis. Mild syphilis does not demand mercurial treatment.

I do protest against treating all cases of syphilis upon a routine plan. Many writers on syphilis lay down the absolute rule that the disease must be treated during a certain specified number of months or years, without even hinting that, for various reasons, one patient may not require as much treatment as another. In our text-books of the present day the description of syphilis rarely corresponds with the average case in practice, but it is the description of the superior and comparatively uncommon forms of the disease. The question is not what the disease is capable of doing, but what it is likely to do. There are cases of syphilis which demand two three, or, perhaps five years of treatment. But it seems to me to be utterly impossible to fix a certain time as the duration of treatment for all cases. When the early symptoms are slight and disappear under treatment, I deem it quite necessary to continue the use of mercury for two or three years to en-

tirely eradicate the disease and prevent subsequent manifestations. Late lesions of syphilis frequently do occur after prolonged administration of mercury. My own practice is to give mercury in every case during the existence of any symptom of the disease, whether it occurs early or late. In the early period I continue the use of mercury for six months after the last symptom has yielded. I then stop the administration of the drug and await further developments. If the symptoms reappear, I resort again to the use of mercury, and continue for perhaps two or three months after the disappearance of the latest symptoms. In late syphilis I give mercury to subdue any growing symptom and then stop.

Iodine and its Compounds in the Treatment of Syphilis.

Prof. GEO. HENRY FOX A.M., M.D.
(*Ibid*).

Iodine has been strongly recommended as an anti-syphilitic remedy by various writers. The drug is rarely employed, and appears to me to have fallen into disuse. In oral lesions I have obtained such satisfactory results from the use of iodine that I am inclined to believe that in cases where mercury produces little effect, iodine would be advantageous. It is the prevalent belief among authoritative writers that the iodide of potassium has no actual curative effect in the treatment of syphilis, but merely a power to cause the disappearance of certain symptoms, and furthermore, that it has little or no value in the early stages of the disease. I believe that in the early stages of syphilis, iodide of potassium is an invaluable therapeutic agent. In many cases of chancre characterized by massive induration I gave the iodide of potassium, and apparently with the effect of reducing its size. In the stage of efflorescence I must admit that the

drug has little or no effect upon the cutaneous manifestations. Still, as the drug causes an increase in the number of blood-corpuscles, it has the same right as mercury to be ranked as a tonic. In ulceration of the tongue and mucous patches I have seen good results following the iodide of potassium, when mercury had been given for several weeks with no effect. In the cure of cephalalgia and arthritic pains associated with the first outbreak of syphilis, the iodide of potassium displays its remarkable power. Of the great value of the drug in late syphilis I need not speak. Its power is often exerted in a most brilliant manner when its administration is preceded by a course of mercurials. I can recall cases syphilitic orchitis where the drug has been seen to have little effect, but on resuming the iodide of potassium after a course of mercury, the swelling of the testicle was lessened with surprising rapidity. The iodide is best prescribed in an aqueous solution, a cubic centimetre containing one grain of the drug. Iodide of potassium is a remedy which no patient ought to be compelled to take for a great length of time. It does its work quickly or not at all. When unnecessarily continued it is sure to do harm. It is undoubtedly true that a five-gramme dose will sometimes accomplish a result when four grammes will produce no effect. For every case of syphilis which I have seen benefitted by immense doses of the iodide I have seen at least two cases in which large doses have done harm. Several physicians have told me of cases of syphilis in which the symptoms were frightful to an extreme degree, and could only be kept in abeyance by the continuous administration of immense doses of iodide of potassium. I cannot, from my own experience, believe that there are such cases, and I

am sure that in some instances the symptoms of iodism have been mistaken for the effects of syphilis. I do not deny the value of large doses of the iodide of potassium in certain cases, but I protest against the continuance of large doses in chronic syphilis.

Where there is dyscrasia and a weakened state of the digestive organs, I have great faith in the iodide of starch. Iron is a remedy which in the treatment of syphilis is of very great value. It deserves to be ranked with mercury and the iodide of potassium. Its power to combat the anæmia which is invariably present in the early stage of syphilis renders it a most invaluable adjunct of mercury.

I should prescribe it for a patient presenting the chancre or initial lesion, and give it as routine in the secondary lesions. It tends in a slight degree to lessen the probability of subsequent manifestations. In the weakened state of the system associated with late syphilis, the value of iron is too well known to require mention, but in the early stage of the disease its value seems to be unknown or unappreciated. I should employ the tincture of chloride of iron in daily doses of ten to fifteen drops. Cod liver oil is a remedy which is not infrequently of service in the treatment of syphilis. When an individual with a strumous diathesis is affected by this disease, its symptoms are apt to be severe and prolonged, and amenability to mercurial treatment is greatly lessened. In these cases the use of cod-liver oil, alone or in connection with iron, is likely to be productive of good results. In late syphilis of an ulcerative type, I have repeatedly seen mercury fail to do good at first, while after the administration of oil for a month or two, it has accomplished all the good that could be expected from its use.

Syphilis Treated by Subcutaneous Injections of Mercury, Peptones, and Ammonia.

M. MARTINEAU (*Concours Médical*), wishing to make a series of experiments with peptones and mercury, procured a carefully prepared solution containing—

Bichloride of mercury, 150 grains; dry peptones, 225 grains; pure chloride of ammonia, 225 grains.

This he mixed with a variable proportion of water and glycerine, according to the concentration desired. M. Martineau has applied this treatment to a great many patients, having up to the present time administered some thirteen hundred injections. He first gave, every third day, an injection containing $\frac{1}{30}$ of a grain of sublimate; while for the purpose of comparison, another series of patients, were at the same time, and like manner, receiving injections of only $\frac{1}{60}$ of a grain. Meeting with no local symptoms, he next gave these injections every two days, then every day, and finally gave as much as from $\frac{1}{30}$ to $\frac{1}{15}$ of a grain daily. He now uses as high as $\frac{1}{12}$ of a grain without experiencing any trouble, and proposes increasing this dose to $\frac{1}{10}$, or even $\frac{1}{8}$ of a grain, if the preparation continues being well tolerated.

During the course of this treatment no local symptoms have ever been observed, no indurations, nor abscesses, and no salivation has been induced; but care should be had, in giving injections, that it be exactly in the subcutaneous cellular tissue, and the back should be chosen in preference to any other region, because there the sub-dermic cellular tissue is loose and abundant. In the great majority of cases no pain was produced. Two or three patients experienced a slight burning sensation, which lasted for several hours; while five others only felt some little warmth, which passed off in less than an hour. When pain

was produced it appeared after the first two or three injections, but never continued beyond the fourth. Even when as high as $\frac{1}{15}$, and even $\frac{1}{12}$ of a grain were being given daily, no stomatitis nor any gastro-intestinal troubles have followed. This mercurial solution, administered in the form of subcutaneous injections, appears to have a more marked and rapid effect on the evolution of syphilitic symptoms than sublimate given by way of the digestive tracts. It will be found of especial value in those serious cases of syphilis where the symptoms are of so threatening a nature that they call for quick and decisive action. This therapeutic process is easily applied, and gives neither pain nor unpleasant symptoms of any kind.—*Med. and Surg. Reporter*.

Anæmia Dependent on a Syphilitic Taint.

R. Tr. ferri perchlorid., 3 $\frac{1}{2}$; potassæ chlorat., grs. 120; liq. arsenicalis, min. 15; aquæ, ad. 3 8.

M. Sig.—One-sixth part three or four times a day in a wine-glassful of water.—*Med. Gazette*.

Effects of Excision of the Syphilitic Chancre.

M. MAURIAC reports (*Gazette des Hôpitaux*), seven carefully recorded cases in which he excised the initial lesion of syphilis. In six, excision was performed at periods varying from sixteen to eighteen days after the appearance of the sore. In the seventh case, the initial lesion was excised, about fifty hours after it had been first noticed, and before there was the least trace of glandular enlargement; but in this, as well as in all the others, the operation was unsuccessful in preventing further development of the disease.—*London Medical Record*.

On the Use of Tents and Bougies.

Dr. EDWARD T. WILLIAMS (*Medical and Surgical Journal*): The knife, in modern surgery, seems to be regarded as the panacea for every ill. It was otherwise among the ancients, who, though behind us in knowledge, often showed themselves before us in common sense. They always viewed the cutting instrument in its true light, as the surgeon's last and worst resort. The popular method of treating sinuses is a good illustration of this backward progress of surgery. We hardly hear nowadays of any way of treating a sinus except by laying it open. This leads me to speak of a simpler method which I have tried successfully a number of times—the use of tents. I speak only of simple sinuses, such as are usually treated by cutting. Take a narrow strip of sticking plaster and fold it, or roll it lengthwise between the fingers, as one rolls a slip of paper to light a lamp or a cigar. Push it to the bottom of the sinus, and leave it three or four days, till it excites a healthy supuration. Then remove the tent, bringing the walls of the sinus together, if necessary, by a bandage or adhesive strips, and let it heal from the bottom, like a fresh wound. This acts on exactly the same principle as the knife or caustic, namely, by exciting an active and reparative inflammation in the place of a chronic and stationary one. I do not say that it will take the place of the knife in all cases, but it certainly will in many. It is an old plan, but one that ought not to be dropped altogether out of mind. It is beyond doubt that *fistulæ in ano* have often been cured by this method, or by the seton, which acts in the same way, and that this is the real secret of the success obtained by certain empirics in the treatment of that disease.

Two special applications which I have

made of the same essential principle I would like particularly to notice.

The first is the application of a *bogie à demeure* as a substitute for cauterizing or curetting the uterus in chronic endometritis. Pass in a common urethral bougie and let it remain a short time in the womb. I have never ventured to exceed five or ten minutes, but have seen it followed by a decided relief of symptoms.

The second is the same thing applied to the urethra (male) in cases of gleet and seminal emissions. Both these conditions, as it seems to me, are most frequently kept up by a kind of chronic prostatic urethritis, with probably a granular condition of the mucous membrane. The prostatic portion is super-sensitive, and sometimes bleeds a little on the passage of an instrument. The *sonde à demeure* is admirably adapted for these cases, and though perhaps less effective in a bad case than cauterization, has neither the risk nor the painfulness of that method. The principle, in all cases, is exactly the same, the substitution of an acute inflammation with a tendency to heal, for a chronic one with a tendency to persist.—*Med. and Surg. Reporter*.

Circumcision as a Sanitary Precaution.

Dr. EDWARD T. WILLIAMS (*Boston Medical and Surgical Journal*) thus discourses on the sanitary value of circumcision:

"It probably does good in several ways.

"1st. The exposure of the glans penis to the air and to friction from the clothes dries and hardens its surface, and renders it less liable to abrasion in sexual intercourse, and consequently to venereal ulcers.

"2d. The removal of the foreskin is acknowledged to be useful as a preven-

tive of masturbation. It not only renders the act itself more difficult, but by diminishing the sensibility of the part and favoring the removal of irritating secretions, diminishes also the propensity to the act.

"3d. It prevents the accidents of phymosis and paraphymosis.

"4th. It prevents the retention of the sebaceous secretion and the ensuing balanitis.

"5th. It probably promotes continence by diminishing the pruriency of the sexual appetite."—*Ibid.*

Iodoform in Orchitis.

The following formula is recommended in orchitis by the *Union Méd.*:

Iodoform four and vaseline thirty parts. Frictions are to be made with this on the painful testicle in orchitis and neuralgia of the cord, supporting the organ by a suspensory. If mercurial ointment has been previously used, it must be carefully washed off, lest the iodide of mercury, which is a caustic, might be formed.—*Ibid.*

Balano-Postho-Mycosis.

This term is applied by Dr. O. SIMON (*British Medical Journal*) to an affection of the glans penis, peculiar to diabetes produced by a fungoid growth. The first symptom noticed is a slight irritation, with some erythema, followed by more intense inflammation and secretion. Afterward the part becomes excoriated and phymosis perhaps results. Eventually a condition resembling papilloma acuminata makes its appearance. Occasionally growths of a callous type appear. Salicylic acid locally is the treatment recommended.—*Chic. Med. Review.*

Atropia in Chordee.

The following formula will be found of great value in chordee:

Sulphate of atropia, four grains, aqua-

rosa, two ounces, Misce: Signa, saturate a little absorbent cotton with the solution, and after retracting the prepuce, lay it behind the glands penis and push the prepuce over it. Repeat this procedure every three hours.—*North Western Lancet.*

DISEASES OF THE SKIN.

The Permanent Removal of Hair by Electrolysis.

The following is a portion of a paper read by Prof. GEORGE HENRY FOX, A. M., M. D., before the Medical Society of the County of New York, and published in *Medical Record*, March 11th, 1882:

We note instances of hypertrichosis on every hand, in the drawing-room, upon the street, or wherever ladies congregate, and could we but know the secrets of the *boudoir* we would be surprised to find how large a percentage of our female acquaintances resort occasionally, if not habitually, to the use of the depilatory, the razor, or the tweezers.

This abnormal growth of hair is not always a trifling matter. It may not kill the patient, it is true, but it is certain to occasion great annoyance. It is very apt to affect her disposition, and to injure her prospects in life, especially if she be young and unmarried; and it may eventually ruin both her health and her happiness by producing a mental disquietude which in many instances verges on melancholia. The frequent occurrence of facial hairiness among insane women has been observed by several writers, and although in such cases the insanity has usually preceded the abnormal growth of hair, I have no doubt that in many instances the mental worry occasioned by slight facial hairiness has acted as an exciting cause, and served to develop an insane tendency. I have certainly treated one or two females who

were monomaniacs on the subject of their facial hairiness, even when this has been very slight, and the most satisfactory result of treatment in these cases has been the improvement in general health which has followed the removal of the hair, which served to make their lives unhappy.

The operation for the permanent removal of hairs by electrolysis is a simple one, which any physician with a steady hand and keen eye can readily perform, although, as in many other simple operations, a peculiar dexterity is required, and far more satisfactory results are obtained after a certain amount of experience. An ordinary galvanic battery is required and a fine needle; which is to be attached to the negative cord. The number of cells required for the operation depends upon the activity of the battery, the delicacy of the patient's skin, and the strength of the hairs to be removed, and should be determined in each case by the effect which is produced. I commonly use from ten to sixteen cells of a zinc carbon battery, or a corresponding number of a chloride of silver battery.

Upon the style of needle employed depends, in a large measure the success of the operation. A fine cambric needle, which has been recommended, may be successfully used, but on account of its stiffness it is more difficult to introduce it into the follicle without piercing the follicular wall than the hair-like flexible steel broach which I have recommended and invariably use. The cambric needle being larger is also productive of more inflammatory reaction, and more likely to leave permanent traces of the operation. Formerly I used a very fine platinum wire, pointed by means of a jeweler's file, but the delicate flexible broach, much finer than those commonly employed by dentists

in extracting nerves, is far superior to any other needle which I have ever seen, and is almost a necessity in removing the hairs from the upper lip without the production of a scar. The needle can be readily attached to the end of the battery cord by a few turns of copper wire protected by an inch or more of rubber tubing, or a special handle may be made for the purpose.

Provided with battery and needle the next thing is to get the patient in a proper chair and in a proper light. A high reclining-chair and a southerly bay-window are desirable, but the main point is to secure sufficient light and to have the operator's eyes upon a level with the patient's chin. The needle is now introduced into the follicle by the side of the hair. If this is skilfully done, no pain whatever is felt by the patient. The sponge cup, or sponge-tipped positive electrode should now be used to complete the circuit. This may be applied to the skin in the immediate vicinity of the hair if but a few cells are used, but it is usually more convenient to allow the patient to hold the positive electrode in one hand, and when the needle has entered the follicle, to ask her to complete the circuit by applying the moistened sponge to the palm of the other hand. The electrolytic action now manifests itself subjectively in the form of a sharp stinging sensation, and objectively in the form of slight hyperæmia around the needle. In a few seconds the hyperæmia will give place to a blanching of the skin, and a little froth will appear at the mouth of the follicle. If the hair be now seized with a pair of forceps and the gentlest traction exerted, it will be found to be loose in the follicle in the course of from ten to twenty seconds, provided the needle has been skilfully introduced. Before withdrawing the needle the patient should

remove her hand from the sponge, in order to avoid the slight shock which would otherwise be felt.

Under no circumstances do I ever remove the hair until it is loosened by means of the electrolysis.

As to the number of hairs which can be removed at one sitting, I would say that from thirty to fifty is the number which I usually expect to destroy in an operation lasting three-quarters of an hour. Upon the neck it takes much longer to destroy hairs than upon the chin or cheeks.

If the operation is skilfully performed it ought not to leave scars, as a rule. In some cases it is impossible to prevent the production of minute punctate cicatrices, which, however, can only be seen on close inspection. I made a mistake in some of my earlier cases in operating upon two or more coarse hairs very close together, instead of taking one here and there at short distances apart. A little attention to this hint may serve to prevent the production of slight scarring by those who may attempt the operation.

As regards the immediate success of the operation, it must be stated that, as a rule, a certain percentage of hairs will return and demand removal a second time. I used to expect a return of from thirty to fifty per cent. of the hairs, while now I am surprised if from five to ten per cent. reappear. In one case, in which I removed over fifty hairs with unusual care, not a single one has returned after an interval of three months. In some patients the growth of hair appears to have ceased, for some unknown cause, and when the hairs are destroyed the cure is effected. In other patients the fine hairs are constantly growing larger and darker, and after the most conspicuous have been removed a new growth will in time succeed, and ap-

pear, perhaps, like a return of those previously removed.

In this operation for the permanent removal of hair the question arises as to how the electricity destroys the papilla from which the hair springs. Is it by thermic or by electro-chemical action? A recent writer on the subject objects to the use of the term electrolysis as being a misnomer, claims that the heat generated in the needle by the passage of the electricity is the active agent in the destruction of the tissue, and suggests for the operation the name of *akido-galvano-cautery*. It cannot be denied that in this operation the temperature of the needle is slightly raised by its resistance to the galvanic current, but surely not to such a degree as to produce a caustic effect. On the other hand, it is evident, from the frothing seen at the mouth of the follicle and other effects, that a decomposition of the water and salts contained in the cutaneous tissues is taking place around the needle and causing the escape of bubbles of hydrogen. This is certainly nothing more nor less than electrolysis.

In conclusion I would like to refer to the cause of facial hirsuties in females, and I shall speak briefly on this point, for I know very little about it. I have wondered and pondered by the half-hour while operating on cases, and endeavored to find some characteristic common to all of my patients, but in vain. Some are in fine physical condition, while others are debilitated. Some are extremely nervous; some are not so in the slightest degree. Some are stout and others thin. Some are of dark and others of light complexion. Some are maidens from twenty to fifty years of age; while of others who are married, some have children and some have none. The somewhat common idea that the growth of a beard in the female is necessarily asso-

ciated with masculine traits of character is certainly not founded upon fact, for most of my patients have presented the very highest type of feminine refinement. That facial hirsuties is dependent upon a malformation or imperfect development of the reproductive organs, as some have claimed, is, in my opinion, doubtful. Certainly, an intimate relation between these two conditions has not been satisfactorily proven, save in a few exceptional cases.

The relation of facial hairiness in females to derangement of the nervous system is a subject which has already commanded attention, but has not as yet been sufficiently studied. I have already spoken of the depressed mental condition existing in many of my patients, and which I believe to be not merely a result of the disfiguring growth of hair, but a symptom of general nervous disease, upon which the hirsuties in all probability depends. Excessive growth of hair, whether in the male or female, is an aberration of nutrition, and not a sign of excessive vitality. The Samsons of the present day are clean limbed, and usually short-haired specimens of the human race, and in our highest type of feminine health and beauty there is but a moderate growth of hair. The lady in the museum, whose luxuriant tresses trail upon the floor is rarely, if ever, well-developed, and, like her bearded sister, furnishes unmistakable evidence of perverted nutrition.

An abnormal growth of hair, whether it be in respect to length or location, indicates an abnormal condition of the nervous system. Precisely what this condition may be, and how it may be remedied, I must leave for others to determine.

Sulphur for Pimples on the Face.

The usual lotion of the flowers of sulphur with glycerine and water is undoubtedly a valuable remedy, but from the readiness with which the sulphur separates it is inelegant and inconvenient, while it is not quite satisfactory in its results. A far more efficacious mode of using sulphur is to dust the face with pure precipitated sulphur every night with an ordinary puff used for toilet purposes. Recently two severe cases of acne of two years' standing, which had resisted the ordinary methods of treatment, yielded at once to sulphur thus applied. If the sulphur be scented with oil of lemon or roses it will form an elegant cosmetic.—*Practitioner—Can. Med. Record.*

On the Removal of Warts.

Dr. W. ALLAN JAMIESON (*Practitioner*): Chromic acid, one to one of water, is by far the best remedy. The skin round each wart is first protected by painting with oil, and then the wart itself is soaked with the solution of chromic acid; this absorbs water from the tissues, coagulating and hardening the albuminous tissues at the same time, and the unsightly warts soon disappear. These warts seldom appear after puberty on the hands, but a healthy girl, well grown, aged fifteen, came to the writer some time since with dozens of them on her hands, which had annoyed her for six years. Of course they much interfered with work, being always in the way. Steady use of the chromic acid removed them in a few weeks.—*Med. and Surg. Reporter.*

Inflammation of the Hair Follicles of the Nose.

Dr. HARDAWAY (*St. Louis Cour. Med.*): They give intense pain, and there is

much inflammation externally as well as within, and very frequently, after the inflammation of the hair follicles subsides, it is followed by exfoliation of the outer portion of the skin of the nose; in other words, the patient has a very red nose. Externally it is generally limited to one or the other side; there is a great deal of sharp, very acute, intense pain. The cases generally continue for weeks, very frequently last several weeks, and when it subsides, there is considerable epidermic shedding—desquamation—showing the violence of the inflammation. He uses Squibb's glycerole of the subacetate of lead and glycerine, one part of the first to seven of the latter. Under this treatment, the trouble disappears rapidly.—*Ibid.*

Nits in the Hair.

From the London *Lancet* we note the two following methods of removing nits from the hair:

1. Apply spirits of wine freely, so as to dissolve the glue which attaches the nits to the hair, and then wash them away with soap and water.

2. Apply to the hair rather a strong decoction of larkspur seeds (*Delphinium staphisagria*). This will kill the parasites very quickly. Wash the head with carbolic soap, after two or three days. The nits will then readily come away by brushing and combing.—*Ibid.*

How to Remove Corns.

Saturate a small piece of cotton with alcohol, apply it to the corn for a minute, then with a sharp scalpel or knife carefully separate the corn from the healthy tissues, which is easily done by a careful handling of the knife and gentle pulling with forceps, while the parts are being immersed with alcohol. If the alcohol dries away while operating, apply the saturated cotton again, and I

frequently find it necessary to apply this several times before the operation is completed. The alcohol not only lessens the sensibility of the parts, but it facilitates the separation of the hard corn from the soft and tender tissues. This cures, and that without drawing a drop of blood or producing any pain, except what results from pulling on the corn with the forceps. After raising one edge, it is about like removing a piece of adhesive plaster.—*American Med. Journal.*

Simple Remedy for Chafe.

Bathe parts well in tepid water, dry well with soft cloths, and apply, by means of a soft sponge or cloth, the following:—Zinci acetatis, gr. xv; Morphiae acetatis gr. ij; Glycerin., aq. rosæ, aa $\frac{3}{4}$ ij. M.

Ft. sol. Sig. Apply to chafed parts twice or thrice a day.—*Boston Journal Chemistry.*

Boracic Acid as an Antiseptic in Skin Affections.

Dr. GEORGE THIN, of London, emphasizes strongly the advantage of using some preparation of boracic acid to overcome the offensive odor of the feet, and gives instances in which this treatment has been thoroughly successful. In some cases he recommends the wearing of stockings and cork-soles saturated with the acid. In others he prescribes an ointment, or rather a kind of glycerine cream, made as follows: a solution of boracic acid is incorporated with a fatty basis of white wax and almond oil, which produce a soft, homogeneous mixture, free from the irritating crystalline plates of the crystal that are apt to separate from vaseline. He finds that this is also a very useful remedial agent for inflamed feet, as after long walking tours, and in such eczemas as are produced by the irritation of dyed underclothing.—*Med. Record.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Fracture of the Clavicle treated with the "Back Sling."

LORENZO HALE, M. D., Albany (*Med. Annals*). E. M. Moore, M. D., of Rochester, has well shown the faults of the treatment with the axillary pad. While the theory of treatment as developed by him is demonstrably correct, yet his bandage—"a shawl," "eight inches in breadth" "when folded,"—appears to be somewhat cumbersome and warm; and, in passing over and in front of the injured shoulder, it lies over the depressed fragment, and hides the fractured bone away from inspection; and, when firm extension is attempted, pressure appears to come on the already depressed fragment.

These undesirable conditions are obviated by the use of a sling, applied by holding one end of a narrow roller bandage against the scapula of the sound side, and then passing the bandage under the forearm of the injured side near the elbow (the elbow being first bent and drawn back), thence up, around and over the same forearm and across the back to the axilla of the sound side, then in front of and over the sound shoulder to unite with the end held at the place of beginning (see figure No. 1). It is not always necessary that the bandage should be thus officinally crossed on the back; but a "back sling" forming parallel lines on the back, although slightly cooler, is not quite as secure.

And further,—instead of finding support for the hand by a sling in front,

fastened directly over the fractured clavicle,—a narrow strap may pass from the wrist across the chest to the "back sling" on the sound shoulder. The front support is thus entirely away from the weak shoulder, and tends to lessen the strain and chafing of the bandage on the sound shoulder (see fig. No. 2).

This dressing admits of the application of a compress over the inner fragment, to be held down with adhesive



FIG. NO. 1.

plaster; but, except when the clavicle is broken into more than two fragments, a compress will seldom, if ever, be necessary, since the "back sling," in drawing back the humerus, makes traction upon the clavicular portion of the pectoralis major—opposing the clavicular fibres of the sterno-mastoid which have drawn the inner fragment upward—and thus

pulls the inner fragment of the clavicle downward.

The outer fragment is also acted upon by this drawing back of the humerus, for the scapula is pushed upward and inward toward the spinal column, and, through the medium of the scapulo-clavicular articulation, the outer fragment of the clavicle is brought upward,



FIG. No. 2.

and extended outward, and the axes of the two fragments are firmly held in one continuous line.

Hence, the "back sling," in holding back the humerus, is seen to fulfil what have always been specified as the indications in the treatment of fractured clavicle, viz., to support the shoulder in a direction *upward, backward and outward*.

Similar anatomical conditions to these above detailed are obtained, although to a less degree, by simply pinioning the forearm of the injured side behind the back; this posture is more uncomfortable and less effective than the "back sling," but may be necessary in the treatment of fractured clavicle in impru-

dent or insane patients, where it would not be safe to permit even the slight freedom of motion allowed by the "back sling."

This "back sling" should be of some material that will not cut nor wrinkle, such as suspender webbing or a wide leather strap; it is light and cool; it leaves the site of the fracture *at all times accessible* (see figure No 2); it safely allows a moderate and comfortable degree of motion in the forearm and hand; it gives the patient an immediate sense of security and relief, and is followed in practice by a result that approximates perfection. As it is to be applied over a portion of the clothing, which serves in a measure the purpose of padding, it is agreeable to the patient.

Aged persons and others whose flesh is soft or œdematous require some form of protecting splint or padding, as a saddle or muff on the forearm, and also padding in front of the sound shoulder, and in some cases daily tightening and slackening of the bandage; on this account it is convenient to have the ends of the "back sling" fastened with a buckle.

Operation for the Relief of Varicocele.

Dr. M. H. HENRY (*N. Y. Med. Record*), from an interesting paper, concludes:

1. Varicocele is a disease that may occur at any period from boyhood to middle life.
2. It occurs mainly in early manhood.
3. It is not of such frequent occurrence as generally believed.
4. It is mostly met with in persons of delicate or impaired constitutions, or in those who have become enfeebled by disease or venereal disease, or both.
5. In robust persons it may follow a severe strain, or direct injury in the region of and along the course of the spermatic veins.
6. It is sometimes complicated

with diseases of the testicle, hydrocele and hernia. 7. A correct diagnosis is easily made with ordinary care and attention. 8. Ligation of the veins is not without risk and danger to life, and does not offer any decided prospects of a radical cure. 9. Ligation of the veins does at times cause loss of virility, and atrophy of the testicle. 10. The obliteration of the veins by the galvano-cautery has, so far, proved only a substitute for the ligation of the vessels. 11. Amputation of the redundant scrotum offers at least as good a prospect of cure without any chance of injury to the glands, and without risk to life. 12. Union by first intention becomes as nearly as possible a natural sequence. 13. Dangers from hemorrhage and inflammation are reduced to a minimum. 14. The operation with this instrument is easy of accomplishment.—*Detroit Lancet*.

Treatment of Boils.

Dr. LOWENBERG finds incisions and boracic acid solution the most effective treatment of boils. Holding that they are produced by a microphytic parasite, he rejects the usual emollient treatment. He commences by incising them, after the application of ether spray, and then fomented with a saturated aqueous or alcoholic solution of boracic acid. When the boils are recent, and the patients refuse the permission to incise them, he finds that simple fomentations with boracic acid solution arrests the development of the inflammatory process.

It may be added that certain internal remedies possess a high degree of value in a succession of boils, notably the pyrophosphate of soda, and the hypophosphites. The relation of a succession of boils to a saccharine condition of the urine should not be overlooked. This is an unknown cause sometimes of their

persistence in spite of all the usual remedies.—*Medical News*.

The Abortive Treatment of Felons with Copal Varnish.

Dr. A. B. ISHAM, of Cincinnati, bears testimony to the value of this method in a recent number of the *Medical News*. The plan was suggested by an old darkey in the vicinity, and consists in wrapping the affected part in flannel bandages saturated with copal varnish and covered with dry flannel envelopes externally. Thirteen cases have come under observation in the past year. In six, suppuration having already occurred, incision was resorted to; in the remaining seven, the copal varnish was the only agent used. The thumb was involved in two cases, the index in five. "In all there was swelling, redness, heat, and great pain; in one a vivid erysipelatous blush extended over thumb, wrist, and extensor surface of forearm; in two cases there was apparently a combination of what is popularly called 'run-around,' with felon of the flexor digital surface, about and near the point. Perhaps in none was the periosteum involved, though several did not differ from cases I have seen in the acute stage, where necrosis and extrusion of the terminal phalanx subsequently took place. In all the seven cases there was a rapid subsidence of the inflammatory process and its accompaniments, and by the second or third day the parts were perfectly normal. If the varnish upon the dressings become unpleasantly hard by drying, it may be softened by adding fresh material from time to time. Its removal may be easily accomplished, when found desirable, by rubbing in lard and then washing with soap and water.

Copal varnish consists of copal resin and spirits of turpentine, the latter con-

stituting about three-fourths of the mixture; and Dr. Isham suggests the following *modus operandi*: 1. *By an irritant action* due to the contained turpentine the inflammatory stasis in the tissues is overcome. 2. *By withdrawing oxygen and arresting oxidation* the turpentine checks cell proliferation, liquefies inflammatory products, and renders parasitic microphytes inert; and 3. *By excluding air and by pressure*. The varnish, of course, is impermeable by air and, in drying, it contracts, producing pressure which "modifies the supply of blood, promotes the removal of waste matters, and tends to maintain a steady and continuous stream."

Boracic Acid in Boils.

The Louisville *Medical News* states that boracic acid applied to boils before or after incision will promptly arrest their development. The efficacy of this remedy can be very readily tested by applying the solution freely after incision. We very much doubt its efficacy when applied before incision.—*Canada Lancet*.

Perforating Ulcers of the Foot.

Dr. FRANK D. BEANE (*Med. Times*) concludes an article on this subject as follows:

In the light of recorded cases and the pathology of the disease, our duty would seem to be—

a. In cases where there is no diseased bone, to advise prolonged rest, stimulating applications or poultices, and attention to the shape of the shoes after healing has been accomplished.

b. Removal of all dead or carious bone that can be reached without materially enlarging the already existing ulcer, with subsequent antiseptic and stimulating dressing to induce repair. The patient's

constitutional condition should be given careful attention.

c. When the disease is confined to either the first or fifth metatarso-phalangeal joint, the denudation and destruction of bones being of any extent, amputation of either toe, including the metatarsal bone, should be performed.

d. A relapse following such operation, Chopart's, Pirogoff's or Syme's operation is indicated. In some subjects of greatly lowered vitality (see cases of Sédillot and Savory and Butlin) amputation of the leg would be safer.

Ergot in the Treatment of Ulcers on the Leg.

After narrating nine cases of ulcers on the leg of large dimension (*Cincinnati Lancet and Clinic*), Dr. Myerhoff recommends the subcutaneous injection of fluid extract of ergot, as a method of relieving the troublesome affection. The injection of about five drops was practiced every second or third day near the margin of the ulcer, in the midst of the enlarged veins and infiltrated tissues. The ulcers themselves were covered with a two per cent. lotion of carbolic acid, and the extremity enclosed in a flannel bandage. Eight injections were the largest number required in any case. The operation was followed by considerable pain, lasting from two to eight hours, but abscesses and other evil effects were never observed. Atrophy of the dilated veins ensued in all the cases, and a rapid and, so far as known, permanent cure resulted in every instance.—(*Ded. Wochens.*)—*American Practitioner*.

For the Treatment of Erectile Tumors.

Dr. JUL. MAYER, Court-physician in Planina (No. 39 of the *Wiener Medizinische Blätter*) gives a therapeutic notice relating to the treatment of erectile tumors

by vaccination, from Dr. Constantin Paul, in Paris. His method of application is that he covers the angioma with a layer of animal lymph, then making slight scratches with a sharp needle over it in which it will afterward form linear cicatrices. This communication encouraged me to publish my method of treatment, which I consider in every respect of greater value. I cut from a piece of cantharidal plaster a close-fitting portion to cover the tumor, which, if possible, is firmly pressed on, and, according to the age of the child, as also the susceptibility of the skin covering the tumor, I allow to remain on one-half to one hour, *never to raise a blister*, after which I paint the entire tumor carefully with animal lymph. The benefits of this method are: not the slightest pain from the application, no bleeding, absolute success in the results, and, what is of greater importance, no formation of any cicatrix. A large and prominent angioma, occupying three-fourths of a child's cheek, had disappeared after five months without the slightest cicatrix. — *Med. Bulletin*.

Galvano-Puncture in Aortic Aneurism.

Mr. RICHARD CANNON reports the case of an aortic aneurism which had almost reached the point of rupture, the skin being reddened and very thin over the tumor, which was cured by the insertion of two needles connected with twelve Stohrer cells. It is stated that when the needles were withdrawn no current was to be detected, so the favorable results may with equal probability be attributed to the mere presence of the needles or to the electrolytic action. The needles remained in the tumor only twenty minutes: at the end of ten days the tumor, which had only been the size of a walnut, flattened down to the chest walls, pulsation and redness had disap-

peared, and there was no pain or cough. Iodide of potassium was administered internally throughout the treatment. — *Lancet*.

Extreme Spinal Distortion.

Dr. MORTON (*Med. Times*) exhibited before the Philadelphia Academy of Medicine the following case of extreme spinal distortion in a lad who was brought to his clinic at the Orthopædic Hospital in May, 1881.

Henry N., aged eight and a half years, born in New York. Mother and mother's family all healthy; father was subject to rheumatism, and died of a "rheumatic affection." The boy has never had any of the ordinary diseases of childhood. His appearance is healthy; bowels, digestion and appetite good; he is not small of his age, nor undeveloped. Intelligence appears unimpaired, but speech is rather childish.

The disorders began when the patient was about three and a half years of age. In November, 1875, it was noticed that he used the right hand awkwardly and preferred the left. He sometimes *fell suddenly* when walking. From that time the progress of the disease has been variable. Twice he has been nearly well without any treatment. He is now (May, 1881) decidedly worse than at any previous time. His appearance is well shown in the photograph. He can stand without assistance for a quarter of a minute, or perhaps half a minute, but he then sinks on to the floor or a chair, with his head sometimes resting on the external malleolus of the right leg. He can walk, but only a few steps. He makes the effort, but invariably crosses his legs and falls.

There seems to be a chronic spastic condition of all the muscles of the right side of the body, from the lower border of the armpit to the hip, affecting the

right leg, however, but slightly. When he is in the supine position, his *left* leg is crossed over the right one, at an angle of 40° with the transverse axis of the pelvis. This spasm is persistent in sleep, but less violent. The left leg has a spasm on the adductor muscles, and probably in the psoas. There is no paralysis. The response to the faradaic current is slightly exaggerated in the muscles all over the body, and a very weak current will induce contractions. The examination with the galvanic current was diffi-



cult, owing to the boy's fear of it; but the motor and sensory responses to it appeared perfectly normal. Both erector spinæ muscles responded perfectly. Considering the enormous curvature of the spine, the degree of rotation is very slight.

Diagnosis and Treatment.—Dr. W. A. Hammond had charge of the patient for nearly a year. Soon after the beginning of the disorder he pronounced the case one of "chorea paralytica," and prescribed arsenic and strychnia, and afterwards bromide of zinc. As none of these medicines were productive of

good, Dr. Hammond came to the conclusion that it was not choreoid.

Dr. Hammond has since mentioned the case as one of "sclerosis and atrophy of the cerebellum." In the same place he says that when he last saw the patient there were nystagmus and a "total inability to stand."

Dr. Sayre saw the boy not long after Dr. Hammond, and considered the disorder due to reflex incoördination from a contracted prepuce. He recommended circumcision, which was performed—without good result, according to Dr. Hammond.

Dr. Mitchell considered the trouble choreoid in its nature, and recommended rest in bed, with massage and hypodermic injections of Fowler's solution in increasing doses.

The treatment which the boy had been subjected prior to and after admission having been without benefit, I determined to rectify, as far as possible, the symmetry of the spine, and then to place upon him a felt corset. Having secured the valuable services of Mr. W. H. Johnstone, the lad, after complete anæsthesia, was placed in extension in his apparatus, and by these means the body was effectually and readily straightened, and a very perfect plaster cast of the chest and body was made. A felt splint was then moulded, which laced up in front, and with this the boy has been enabled to walk almost erect, with great comfort, since May, 1881, to the present time. January, 1882, again we admitted him to the Orthopædic Hospital, and lateral steel supports which extended from the spinal jacket to the shoes were added to the brace, which proved of considerable service, the lad readily walking with the additional aid of a cane, and without difficulty can walk erect. The deformity, however, recurs when the splint is removed.

Palsy of Both Lower Extremities.

Dr. MORTON (*Med. Times*) presented the following case before the Philadelphia Academy of Surgery, of complete (infantile) palsy of both lower extremities, involving the thigh and leg muscles, in which the paralyzed limbs were util-

and was sentenced for life to the pauper department. I was asked to visit him, in order to give an opinion whether or not in any way he could be relieved and made to walk, as he was soon to be transferred from the youth's department, where he had been so long, to the pauper portion of that institution. His only



ized by flexing the legs upon the thighs, thus forming a support for artificial limbs, which have been worn with success for a year.

H. B., aged 18 years, had been an inmate of the Philadelphia Almshouse for many years, was deemed an incurable,

method, I found, of locomotion was by dragging his body along the floor by means of his hands and arms. I found that he had considerable control of the muscles of the upper part of the thighs. The limbs were extremely atrophied, and presented the usual appearances in such

cases. He had been in the habit of keeping his legs tightly drawn upon his thighs, partly for convenience sake; and it then occurred to me that if the atrophied legs and thighs were closely bound together, an excellent support might be obtained for an artificial limb. Artificial limbs were adapted and the result has proved most satisfactory. The lad can now walk a mile or more with the aid of a cane; he has been enabled to earn his living without difficulty at cigar-making, and his physical and mental condition have astonishingly improved.

DIGESTIVE TRACT.

Intussusception.

In a case of intussusception in which the descending bowel could be felt in the rectum, Dr. McGOWN, (*Brit. Med. Jour.*) resorted successfully to the following experiment: Obtaining a piece of sheep's colon six inches long, he tied one end and connected the other to a piece of rubber tubing a foot long, through the interposition of a short tube of ivory. The apparatus was completed by attaching the free end of the rubber tube to a stop-cock. The sheep's colon was now passed into the rectum through a speculum, blown full of air and the stop-cock closed. The pressure thus exerted on the prolapsing bowel caused its reduction, and the patient recovered. —*Ohio Med. Jour.*

Treatment of Prolapsus Ani by Hypodermic Injections.

Dr. VIDAL has treated successfully three long-standing cases of prolapsus ani in adults by means of injection of ergotine, a cure being effected in a few weeks. The author therefore recommends that this method should be adopted in similar cases. The method

employed is to inject, by means of a Pravaz syringe, 15 to 20 drops of a solution consisting of one part of Bonjean's ergotine in five parts of cherry laurel water, every two or three days, through the anus, either into the sphincter or into the prolapsed portion of intestine. Severe burning pain follows the injection, tenesmus, lasting several hours, in many cases cramp in the neck of the bladder, and retention of urine for eight to ten hours. The author has not met with inflammation, abscess, or toxic symptoms in any of his cases. (*Der Praktische Arzt*, in *Nov. Practitioner*.) Judging from the immediate effects of the operation, I think it would be hard, in this country at least, to prevail on the patient's submitting to a second injection; besides, it offers no advantages over Dr. Van Buren's method of treatment by actual cautery. —*Can. Med. and Surg. Journal.*

Puncture and Aspiration in Intestinal Invagination.

We read in the *Paris Medical*, Jan. 28th, 1882, that Dr. Godfrey has treated a case of intestinal invagination as follows: The patient, a man 37 years old, was vomiting a greenish yellow liquid having a most offensive fecal odor. His abdomen was distended, and very tender to the touch; and distinct fluctuation together with dullness were perceptible over the entire course of the colon. The umbilical region was somewhat tympanitic. Great tenesmus existed, and the efforts at defecation only resulted in the passage of a little bloody mucus. Having carefully ascertained that no hernia existed, the intestine was punctured, first in the left, then again in the right iliac region, the largest needle of a Codman and Shurtleff aspirator being used for that purpose. More than a pint of liquid, similar to that vomited,

was thus withdrawn, and the patient felt somewhat relieved. Vomiting now became less frequent, and finally ceased. Morphine, first hypodermically, then by the mouth, procured sleep, and after three days the intestine had resumed its functions, and in less than a week the patient was again well.—*Med. and Surg. Reporter*.

Treatment of Fissure of the Anus.

DR. MASCAREL proposes the following treatment, which he has used with much success in the case of those patients who fear the radical cure of fissure by forcible dilatation: 1. An enema of warm water, to which a large spoonful of glycerine has been added, is ordered to be given daily. 2. After each motion, a small pledget of lint, saturated with the following ointment, is to be introduced into the anus: R. Glycerine, 30 grams; oil of sweet almonds, 30 grams; brown ointment (*onguent de la mère*), 60 grms. 4. After introducing the lint, care must be taken to smear the ointment well around the outside of the anus. 5. If there is great constipation, five centigrammes of powdered belladonna root should be given every night. In eight cases out of ten, fissures of the anus will be cured after three weeks or a month of this treatment.—*Le Progrès Médical*, July, 1881, quoted in *Practitioner*, Dec., 1881.—*Can. Med. and Surg. Journal*.

DISEASES OF THE EYE AND EAR.

Hypopyon.

THE *Medical Press and Circular* says that Dr. JUST recommends *massage* of the globe of the eye, which consists in pressing and rubbing gently the organ with the lower lid intervening. In this way he has succeeded in causing to be absorbed a purulent collection in the an-

terior chamber of the eye. Another oculist has been able to provoke rapid absorption when the hypopyon was mobile, by making the patient lie alternately upon the right and left side, and causing him to change position every hour.—*Med. & Surg. Reporter*.

Sulphide of Calcium in Strumous Ophthalmia

Is highly recommended by Mr. SIMON SNELL, in *The Practitioner*. It is given in doses of one-tenth of a grain to one-fourth of a grain, three times a day, the usual applications of atropine, poppy fomentations, etc., being employed at the same time.—*Med. Record*.

Earache.

Prof. WHARTON JONES (*Canada Med. Record*): In the course of practice you will often be called upon to attend a case of earache. This means, pathologically speaking, acute inflammation of the *membrana tympani*. Now, in such a case, you may quickly subdue the inflammation, relieve the patient from the excruciating pain he is suffering, and save him, perhaps, from subsequent confirmed deafness. The treatment from which such a desirable result may be obtained is similar to that which you will find so beneficial in analogous cases of eye disease, viz., leeches behind the ear, hydrag. c. creta and belladonna powders, with warm fomentations.

Amaurosis in Yellow Fever.

Dr. JUAN SANTOS FERNANDEZ (*Archives of Ophthalmology*,) reports three cases in which complete amaurosis resulted in the course of yellow fever; in one case an ophthalmoscopic examination was made, but as might have been expected no abnormal condition was detected. He was also able to confirm the

external changes reported to occur in the cornea and conjunctiva, but the existence of temporary amaurosis has not been previously reported. — *Chic. Med. Review.*

Sulphate of Cadmium in Corneal Opacities.

Dr. MIGUEL of the Belgian army, uses the following solution: Cadmii sulphatis, .05 (gr. 3-4), mucil. acaciæ, 10 gram. (3 ijss.) With this solution the spot is to be touched several times in twenty-four hours. — *Paris Médical.* — *Med. Rec.*

Ophthalmic Migraine.

Dr. FÉRÉ (*Revue de Médecine*) recently described a condition which he calls ophthalmic migraine, and which he claims is characterized by the appearance of a luminous spectre sometimes colored, sometimes not; perhaps for this may be substituted the disappearance of a part of the visual field. Either of these visual phenomena is preceded by a headache generally attacking a limited space of the temporal region, whence it spreads so as to involve nearly half the head on the side on which the visual phenomena are most marked. The cephalalgia terminates by nausea, followed frequently by vomiting. Certain vaso-motor phenomena at times present themselves, and Dr. Féré claims that at times even cerebral symptoms, such as localized lesions of sensibility and motility, and temporary impairment of speech are present. It is probable that under this term, ophthalmic migraine, Féré has confounded certain badly observed cases of epilepsy. In the conclusion of his article he hints at the possibility of such an explanation. — *Chic. Med. Review.*

Of Foreign Bodies Remaining in the Eye.

Prof. LEBER, of Göttingen, claims that inflammation and suppuration following the accidental lodgment of foreign bodies

in the eye are not due to the foreign body *per se*, but either to septic matter carried in with the foreign body and undergoing decomposition, etc., or some chemical change in the body itself. In corroboration of these ideas he cites instances from antiseptic animal experimentation, where bits of clean glass, gold, etc., have remained in the different chambers of the eye for a longer or shorter period, and yet caused no inflammation, whereas similar but non-antiseptic experiments have resulted in suppuration, atrophy of the retina, cloudiness of the cornea, hemorrhages into the anterior chamber, and finally total loss of eyesight. He concludes that similar results follow like experiments upon the human eye, and instances one case where a clean piece of iron penetrated to the ciliary region through the cornea and lens, the result being a corneal cicatrix and traumatic cataract. But no inflammation ensued until months had elapsed, and chemical changes in the iron initiated the morbid processes, resulting in destruction of the organ. Subsequently, when enucleation was performed, the iron was found in a corroded condition, the cornea clouded, the lens absorbed, the vitreous fluid all gone, while the retina was detached and atrophied. — *British Medical Journal.* — *Med. Record.*

Conjunctivitis.

Fluid extract of ergot is recommended (*Am. Specialist*) for conjunctivitis and pannus, used locally as eye drops.

Xanthopsis.

At a recent meeting of the Clinical Society of London (*Lancet*) Mr. W. H. Kesteven read the following notes of a case of xanthopsis. On an exceptionally hot day, last July, a married woman aged twenty-three, having exposed herself to

the full heat of the sun, was seized with acute pain in the occiput, and found that she saw all things red and green. As the pain passed off, in the course of a day or two, this intense coloration diminished. The ophthalmoscope revealed the existence of a large patch of double contoured nerve fibres at the upper part of the disk of the right eye. This, when first seen, was very prominent, and gave evidence of the existence therein of some neuritis. The left disk was normal. The color vision of the left eye was normal, but with the right eye she saw all things yellow. This condition continued for more than three months, and then gradually passed away. The author suggested that the condition might be explained by the violent impression made by the rays of the sun impinging directly on the retina. The case was examined by two other gentlemen, who confirmed the ophthalmoscopic appearances described.—*Med. and Surg. Reporter*.

Stretching the Optic Nerve.

DR. KÜMMELL, of Hamburg, has stretched the optic nerve seven times in five cases. The eyesight had been partly or completely lost from atrophy of the optic nerves. The operation is done by making a slit in the lower and outer part of the conjunctiva near the cornea. A curved hook is passed in and back, the optic nerve is caught and stretched "not too strongly." Very slight symptoms followed the operation. In those cases where the blindness was not complete, there was some improvement.—*Med. Record*.

The Eye and Sexual Excess.

Under the above caption Dr. M. LANDESBERG (*Medical Bulletin*) writes an article replete with facts which every physician should be acquainted with. Cases are

given where complete or partial blindness occurred from unlimited sexual indulgence, and cures were effected by abstinence. One case cited gives the following history: A young man, æt. 19, had been living with two girls, and having intercourse twice or more times each day with both. He came to the doctor with failing sight, intense neuralgic pain and nausea. He was entirely cured by a sea voyage to Lima.—*Detroit Clinic*.

VENEREAL DISEASES.

On the Use of Iodoform Spray.

M. DUJARDIN-BEAUMETZ (*Journal des Sciences Méd.*) recommends a new method for the use of iodoform in the case of syphilitic ulcerations, or those attending vaginitis. By means of the spray, he applies, on the affected parts, a solution of iodoform in ether, of which the following is the formula: \mathcal{R} . Iodoform, gr. xv.; ether sulph. \mathfrak{z} iij. \mathcal{M} .

The spray supplies a regular tenuous deposit of iodoform which reaches every fissure. In this way it is possible to reach these deep ulcerations of the throat, which are otherwise so difficult to get at. The cure of vaginitis is explained by the effects of iodoform on the little ulcerations of the vulva, which are almost always a determining cause in all painful contractions of the ring. Hence iodoform is of no service in any form of vaginitis, other than that due to ulcerations or fissures. The author has made no experiments with his process on anal fissures, for which he still believes that dilation is indicated, but he advises its use in the treatment of vaginitis.—*Med. and Surg. Reporter*.

Tertiary Syphilis and Strumous Skin Diseases.

\mathcal{R} . Pot. iodidi, grs. 3-5; glycerini, 3 2; vini ferri, 3 4; olei morrhue, 3 6. Mix

and make a draught to be taken twice a day.—*Med. Gazette.*

Potassium Bichromate in Syphilis.

Dr. J. E. GUNTZ, Dresden, Germany, (*Med. Record*), claims to have obtained very good results in the treatment and prophylaxis of syphilis by the use of what he calls "chromwater;" that is potassium bichromate dissolved in carbonic acid water. He gives, per diem, three and one-half grains of the salt, divided into five doses, dissolved in a pint and a quarter of carbonic acid water. He claims good results also from this chromwater in diphtheria. The statistics by which he justifies these claims contain numerous possible elements of error in addition to those produced by Dr. Guntz's enthusiasm.

Iron with Mercury.

By giving iron along with mercury, full doses of the latter may be given to very broken-down subjects without fear. My own individual experience has been that while I use mercury very freely in syphilis, no case of salivation or other mercurial trouble has occurred since iron has been systematically given with the mercury.—*Fothergill in Aids to Rational Therapeutics*.—*St. Louis Cour. of Medicine.*

Abortive Treatment of Buboos.

Dr. M. K. TAYLOR (*American Journal of the Medical Sciences*), claims good results in the abortive treatment of buboes by injections of carbolic acid. He reports twenty cases in which he obtained remarkable success, and states that within the last seven years he has treated nearly one hundred and fifty cases of various forms of lymphadenitis, arising from specific and non-specific causes; and where he saw the cases be-

fore the formation of pus was well established, he had not failed to arrest the process immediately and allay the pain in a few minutes. His method is to inject from ten to forty minims of a solution of eight or ten grains to the ounce, of carbolic acid directly into the interior of the inflamed gland.—*Chic. Med. Rev.*

Injections of Bromide of Potassium in Gonorrhœa.

In eighteen patients under observation there was noted in fifteen a rapid diminution or complete suppression of the erections. The injections are not very painful. They are used five times a day, the last injection being practiced just before retiring. They should be retained in the canal one or two minutes.

The following is the formula: Water, 150 grammes; glycerine, 10 grammes; bromide of potassium, 6 grammes; laudanum, 2 grammes.—*Journal de Therapeutique*.—*Cincin. Med. News.*

Sulphurous Acid in Gonorrhœa.

Dr. L. C. CHISHOLM (*Southern Practitioner*) claims that he has secured good results in gonorrhœa by the use of the solution recommended by Dr. Wilson (*Lancet*). This solution consists of one part of sulphurous acid and fifteen of water. Recoveries under this treatment are quick and complete.—*Chic. Med. Review.*

The Microbi of Blennorrhagic Pus.

The *Journal des Sciences Médicales*, states that these microbi have already been noticed, but that Mr. Weiss contributes additional interesting data on the subject. The pus examined was taken from both men and women, and all necessary precautions

observed. In every case, under the microscope, in the midst of the pus globules and epithelial elements, small bodies could be seen, either alone, or united in pairs, or forming more numerous groups, and arranged after a special manner. These corpuscles always have a characteristic appearance. Mr. Weiss examined pus from thirty-two patients, and in each case he found similar parasitical forms. As a check, he examined pus from simple urethritis, balanopostitis, soft and syphilitic chancres, buboes and leucorrhœa, but in no case could he discover the special elements which he considers characteristic of blennorrhagia. Experiments for the purpose of propagation would now be interesting; but they have not, as yet, been undertaken. As regards treatment, Mr. Weiss particularly recommends the parasitocidal qualities of hypermanganate of potassium. In Dr. Spillman's service, in all cases of vaginal blennorrhagia treated by injections with a solution of this salt, in the proportion of 0.25 centigram to the thousand, a rapid and extensive decrease in the number of microbi was noticed; they were found to have lost their coating and to have suffered changes indicating that they had been altered or destroyed by the application of this substance.—*Med. and Surg. Reporter*.

Blennorrhagia Treated by Chlorate of Potash.

The *Paris Medicale*, Dec. 3d, 1881, reports that Zeitlin has treated fourteen cases of blennorrhagia with chlorate of potash, administered internally, in daily doses of three grams (grs. xl.) according to Dachman's method. The results have always been satisfactory. After a few days micturition becomes painless, erections cease, and the discharge is less abundant and more serous.

The happy effects of this salt are due

to the rapidity with which it is excreted by the kidneys, without any change in its composition, and to its local action on the urethral mucous membrane.

Good results have also been obtained with chlorate of potash, prescribed as an injection, and in cases of blennorrhagic or other cystitis, its internal use has been found beneficial.—*Ibid*.

DISEASES OF THE SKIN.

Chrysophanic Acid in Psoriasis.

Chrysophanic acid has been used successfully for some time as a remedy for psoriasis. It is, perhaps, the best remedy we possess for that affection. Where, however, the skin affection is extensive, or the remedy too strong, it sometimes causes sickness and vomiting. It may be applied in combination with melted lard, or what is better, with vaseline, in the proportion of from 30 to 60 grains to the ounce. Dr. M. Charteris, of England, has been using the remedy, in combination with vaseline, with complete success in quite a number of cases. In a case where the disease (*psoriasis*) extended over the whole body, the usual formula of 1 to 8 of vaseline, was found too strong; nausea and vomiting occurred, so that he was compelled to apply it of a much weaker strength, viz: 1 to 16. During his experience he learned one singular fact, that where the disease was nearly equal on both sides, or was symmetrical, the application of chrysophanic acid and vaseline to one side of the body, acted equally on both sides. He took patients, so afflicted, covered the arm and leg with close-fitting flannel, so that nothing could touch it, and made the application to the arm and leg of the opposite side. The covered limbs recovered from the affection nearly, if not altogether, as soon as those receiving the ointment.

Treatment of Eczema of the Hand.

Dr. A. W. FOOT (Dublin *Medical Journal*):

The patient was twenty-two years old. The disease was confined to the back of the hand and the clefts between the fingers, where were many fissures, the viscid secretions issuing from which formed crusts with a pustular aspect. The pruritus was very severe.

Each finger and the entire hand were wrapped round with strips of old linen soaked in a mixture of lead lotion and glycerine, and the whole then sealed up in gutta-percha paper. As the itching had quite broken her sleep at night, she had, for two or three nights, draughts with potassium bromide 3 ss. and chloral 15 grs., in chloroform water, and she was ordered five minims of Fowler's solution in tincture of bark three times a day after meals. As there was no reason to starve her, she was given meat and porter every day.

The inflammatory action was soon moderated by the lotion, which was applied fresh every day, and the hand sealed up again after having had a jug of cold water poured over it. It was kept in a sling; the perfect rest obtained by slinging the hand, and the exclusion of the air by the careful sealing up of the gutta-percha cover, are points to be attended to. Whenever the hand was let hang or rest in her lap, it got hot, heavy and swollen, and began to throb. After three days of this treatment, the heat, redness and itching had abated; then a thirty-grain solution of nitrate of silver was carefully painted all over the back of the hand and fingers, from the wrist to the margin of the nails, avoiding the latter, and sealing up and slinging continued. In a few days she got a strong lotion of iodide of potassium to remove the black-

ening effects of the nitrate of silver which it is quickly doing, and the sealing up was discontinued. The arsenic had to be omitted for a few days in consequence of gastric irritation. From this time she improved rapidly to recovery.—*Med. and Surg. Reporter.*

Iodoform in Impetigo and Eczema.

Dr. SEQUIN (*Brit. Med. Jour.*), uses iodoform either pure or mixed with an equal quantity of powdered claret; the latter he is inclined to believe lessens the irritating action of the iodoforms. He first softens the scales by bathing them with soap and warm water, and then completely removes them; the new surface is then dried very gently. The iodoform being then very thoroughly powdered is dusted on, after which glycerine is lightly painted over with a camels hair pencil, which process is repeated during every two hours thereafter.—*Quar. Epitom.*

Palmar and Plantar Eczema.

In some cases the use of cod-liver oil, on the hard, thickened, and fissured epidermis, has had the power of softening and healing the parts. In others the addition of a slight stimulating oil, such as the oil of cade, in the proportion of one drachm of the latter to four ounces of cod-liver oil, applied night and morning, will often by its soothing and slightly astringent action relieve all irritability of the cutaneous muscles and vascularity of the parts.—*Med. Bulletin.*

Eczema of the Scalp.

For the obstinate scurf following eczema capitis, STARTIN (*Med. Press and Circular*) recommends the following:

Red oxide of mercury, gr. v.—0.30 gm.; creosote, ℥ij.—0.12 gm.; saxcera

(a colorless hydro-carbon from petroleum), q. s. M. Apply night and morning. Wash the scalp with warm water and oatmeal or yolk of egg, or glycerine soap, and dry before using the ointment. The creosote may be left out after the first week's treatment.

Vesico-Papular Eczema.

Prof. DUHRING (*Med. and Surg. Reporter*): This young man has a history of a chronic disease of the skin, which, when first seen, was diagnosed as chronic eczema. It occupied the thighs, legs, feet, back, forearms and hands. As you see, he is pale and anæmic. To-day all the lesions are so improved that the former disease is scarcely to be recognized. On the back, however, we observe broken down vesicles in the form of a patch. On the shoulders the disease is more marked, and in the form of vesico-papules. Accompanying the disease there is a great deal of itching. Three or four days ago various sized pustules, now scarcely to be observed, were present. The case is both an interesting and a serious one. The disease first appeared three years ago, in the same form, on the arms. Some weeks afterward the disease repeated itself on the hands, since which time it has been getting "better and worse." For the last six months it has been getting steadily worse, and last month it was very bad, the itching being intense, not allowing him to sleep.

Coming now to treatment: At first we used the "liquor carbonis detergens," a solution of coal tar in alcohol, used in the strength of a f 3 j. to f 3 ij. of water. This was applied to relieve the itching. After ablution with this, he was anointed with oxide of zinc and petroleum ointment, equal parts. Internally he took tr. ferri chlor., grt. x., and quinia sulph., gr. ij., three times a day. Later,

as he was not much better, he was ordered ung. picis et ung. petrolei, equal parts. The next day, as he was markedly worse, it seemed evident that the ointment did not suit him, when he returned to the first line of treatment, and he has since improved considerably. In order to procure sleep, we have been using chloral, gr.xv., et potass. brom., gr. xx.

Heat Eruptions.

Dr. GEO. H. ROHE, of Baltimore (*Atlanta Medical Register*) sums up the treatment of heat eruptions, as follows:

The treatment of the heat eruptions is simple. Cleanliness, light clothing and not too frequent cold bathing relieves the discomfort materially. The boils should be freely scarified, to relieve the hyperæmia, and give exit to any pus or slough they may contain. After bathing, the surface should be lightly dried by a soft towel, and dusted with a simple drying powder of starch or precipitated chalk. Poultices should be religiously abstained from. If any of the furuncular swellings should be very painful and tense, a hot fomentation after incision, continued for about an hour, will be as effective and much more cleanly than a poultice. Internally, the tincture of chloride of iron will, in most cases, be indicated.—*Med. and Surg. Reporter*.

Chloasma.

Dr. UNNA, Hamburg (*Berliner Klinische Wochenschrift*), claims good results from the following procedure in chloasma. The skin is first sponged off with alcohol or cologne, and a mercurial plaster made from white precipitate ointment is applied over the pigmented spots in narrow strips and allowed to remain during the night. The following pomade is used during the next day:

℞. Bismuth subnit., 3 iss.; kaolin, 3 iss.; vaselinæ, 3 vi. to 3 iss. M.

This is applied over the spots and in conjunction with the other treatment is said to effect a rapid cure.—*Chic. Med. Review.*

Treatment of Herpes Zoster.

JOHN BOARDMAN, M.D., reports the following in the *Buffalo Med. and Surg. Journal*:

Case.—M. D. came into my office with an interrupted band of herpes zoster, extending on the right side of the vertebræ to near the pubis, which he discovered two days previous. I ordered him to use the following prescription:

℞. Carbolic acid, 3 ii.; ol. oliv., 3 i. Sig.—Rub well on the parts two or three times daily.

I did not see him for a week, when the eruption had disappeared, only a few dry crusts remaining. He stated that after the second application the burning of the parts was relieved.

My purpose in this brief report is to direct the attention of the profession to the use of carbolic acid in the treatment of "shingles," as it has been very successful in my hands. — *Cincin. Med. News.*

Acne.

INTERNAL TREATMENT.

If constipation exist, saline or vegetable laxatives should be prescribed in sufficient quantity to open the bowels once or twice a day. An occasional dose of blue pill or of calomel will in some cases prove beneficial. Where there is a furred tongue and disorder of the stomach and bowels, excellent results may be obtained from the following:

℞. Magnesiae sulph., 3 iss.; ferri

sulph., gr. xvj.; acidi sulphurici dil., 3 ii.; aquæ, 3 viij. M. Sig.—Tablespoonful to a gobletful of water.

LOCAL TREATMENT.

℞. Sulphur. præcipitati, 3 j.; glycerinæ, 3 ss.; adipis benz., 3 j.; ol. rosæ, gtt. iij. M. Ft. ungt. Sig.—To be thoroughly rubbed into the skin at night.—DUHRING.

Or, Sulphuris loti, 3 j.; ætheris. 3 vj.; alcoholis, 3 ii.—jss. M. Sig.—Apply as a lotion. Shake the bottle before using.—BULKLEY.—*Quarterly Epitome.*

French Treatment of Itch.

At present itch is cured in one hour and a half (at St. Louis Hospital). The first half-hour, the patient, absolutely nude, rubs himself from head, or rather neck, to foot, with soft soap. The second half-hour he is put into a tepid bath, where he continues the soft soap frictions. The third half-hour he rubs his body with Helmerich's sulpho-alkaline ointment. He puts on his clothes without washing off the ointment, so as to keep it in contact with the surface for twenty-four hours. While the patient is treating himself, his clothes are purified in a specially constructed stove at a temperature of 120 degrees, and exposed to sulphur vapour. Four thousand itch patients are treated here (St. Louis) annually. The hospital treatment is a rough one and sometimes causes attacks of eczema. It may be mitigated thus: toilet soap is substituted for soft soap, and Hardy's modification of Helmerich's ointment used—lard, 100 parts; sulphur, 16 parts; bicarbonate of potash, 8 parts, by weight. The patient should have his sheets and all under-linen changed immediately.—*Medical Times, from Gaz. de Hopit.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Fracture of the Neck of the Femur.

Prof. WIGHT, Brooklyn (*Proceedings Med. Society County of Kings*): When we had admitted the uncertainty and the not unfrequent impossibility of making a diagnosis of fracture of the femoral neck, we may ask the following question: "Are there any signs by which we can be reasonably sure that there is a fracture of the neck of the femur, on the supposition that crepitus is absent, and that it is not good practice to try to find crepitus?"

In order to bring some points to bear on the settlement of this question, I have tabulated the records of twenty-one cases of fracture of the femoral neck that I have seen, some with other surgeons and some in my own practice. The records that I have tabulated contain the following measurements: 1. Inside measurements from the superior anterior spines of the ilia to the lower ends of the internal malleoli; 2. Outside measurements from the superior anterior spines of the ilia to the lower ends of the external malleoli; 3. Measurements from the tops of the great trochanters to the lower ends of the external malleoli; 4. Measurements from the bases of the tibiae to the lower ends of the internal malleoli; 5. Measurements from the superior anterior spines of the ilia to a line drawn transversely in front between the tops of the great trochanters. This is the transverse femoral line.

The object of all these comparative

measurements is to determine the possibility of original symmetry of the two limbs, and to find out, as far as possible, if the injury to the hip have caused any shortening of the limb on the injured side, so that we can infer the probability of their being a fracture of the femoral neck. Let me repeat, in this connection, some of the points constituting reliable surgical measurements. 1. The instrument of measurement should be an accurate steel tape-line, with feet and inches on one side, and metres and centimetres on the other side. This tape-line will not elongate under tension, and the ordinary tape-line will elongate under tension. 2. The measurements should be made independently: that is, when one is made, the points of the tape-line should be removed from the surgeon's hands, and new points for the other side of the body should be determined without any reference to the measurement of the first side. 3. In all ordinary cases, the leg may be measured quite accurately by semi-flexing it on the thigh, for this position brings the anterior edge of the base of the tibia markedly under the integument, so that it can be made quite as accurate a point of measurement as the superior anterior spine of the ilium. 4. In most cases the tops of the great trochanters can be so accurately compared as to make the measurement from them to the external malleoli of considerable value. 5. In all cases the personal equation of the surgeon should be most carefully excluded from any measurement. 6. The lower limbs should be put parallel with the pelvis; for in the ordinary measurement adduc-

tion elongates and abduction shortens the lower limb.

1. In all the twenty-one cases above recorded there was more or less obliteration of the abdomino-femoral—or inguinal—fold on the side of the injury. This was probably due to two causes; *a.* Effusion in front of the injured femoral neck; *b.* Contraction of the soft parts in front of the femoral neck. 2. About one-half of the patients were examined standing up; and when the foot of the injured side was brought down to the floor, the gluteo-femoral fold on that side was seen to be lower than the gluteo-femoral fold on the uninjured side. 3. There was out-rotation of the injured limb in all of the above cases. In cases I. and II. the out rotation was not marked. 4. In all the cases of impaction of the base of the femoral neck, the upper end of the femoral shaft was materially enlarged. There were probably eight such cases. 5. In all of the cases of impaction of the top of the femoral neck into the femoral head, the upper end of the femoral shaft was not enlarged. There were probably five such cases. 6. The other eight cases could not probably belong to either of the above classes. 7. In all of the above cases there was more or less prominence of the outside of the hip, but the gluteal region was somewhat flattened; and generally there was a fusiform enlargement of the upper part of the thigh. 8. In fourteen of the twenty-one cases there was more or less asymmetry of the lower limbs; and this point is important for two reasons. First, it was determined by measuring from the tops of the great trochanters. Second, it agrees with the general fact that about two persons out of every three have asymmetry of lower limbs. Hence, the above measurements from the tops of the great trochanters to the external malleoli

were probably correct. Hence, such a measurement may be recommended as a valuable aid in making a diagnosis of fracture of the neck of the femur.

1. The average shortening after fracture of the neck of the femur, as shown by the inside measurement, is about .62 of an inch; as shown by the outside measurement, is about .55 of an inch; and as shown by both measurements, is about one-half an inch, .58. 2. The greatest shortening was one inch and one-half—in Case V. 3. The least shortening was zero—in Case XVI.; but in that case there was an actual shortening of three-fourths of an inch. 4. The average normal asymmetry of the lower limbs in the above twenty-one cases was .4 of an inch. 5. The average shortening of the measurement from the superior anterior spine of the ilium to the transverse-femoral line was about one-half inch, again showing that the top of the trochanter major is an approximately accurate point from which to measure. 6. In the four following cases the injured limb appeared to be shortened one-fourth of an inch by a comparison of the inside measurements.

In no case of fracture of the femoral neck do I use force to find crepitus. I consider the other evidences of fracture, such as I have above enumerated, as sufficient to come to a practical conclusion. Nor do I give an anæsthetic in order to make an examination. In this connection, I would make the following statements: 1. Moving the outer fragment when it is in contact with the inner fragment, will generally carry the inner fragment with it, and there will be no crepitus; and when there is impaction, ordinary manipulation will not cause crepitus to be felt. Yet crepitus may at times be felt, when there is impaction of the neck of the femur. 2. Moving

the outer fragment when it is not in contact with the inner fragment, of course will not give crepitus. 3. Hence, unwarrantable force will be required in order to get crepitus in many cases of fracture of the neck of the femur may be broken up by severe manipulation, and a patient who would have had a useful limb may be quite completely disabled for life; for an impacted fracture of the neck of the femur is the best setting of the bony fragments that the surgeon can have. 4. In a suspected case of fracture of the neck of the femur, I examine all the witnesses of fracture except crepitus; and if these witnesses agree substantially, I pronounce a verdict in favor of fracture of the neck of the femur. And if there be a doubt as to the correctness of such a verdict, I give the patient the benefit of that doubt by treating the case as if there were fracture of the neck of the femur; and then the surgeon receives a benefit from that doubt. But if there be no fracture, the patient has had some days of needful rest, and has had a contused hip well treated.—*London Medical Record.*

Martin's Bandage in the Treatment of Fracture of the Patella.

DR. WILLIAM A. BYRD, (*Med. and Surg. Reporter.*) I was called to see Henry Meyer, an athletic laborer, aged 28 years, who was said to have received a sprain of the knee. When I saw him, I found that, while out hunting, his foot had slipped, and in his endeavor to regain his equilibrium, the right patella was fractured at the junction of the middle and lower third. The fragments were separated sufficiently to admit the thumb being placed between them. There was considerable effusion into the joint, with great pain. Not being able to get a leather or shellac-cloth

splint at the time, I took an inch thick pine board, that would extend from the sub-gluteal fold to below the heel, and so shaped it that it was about as wide as the greatest diameter of the leg, except just opposite the joint, where I made projections, so that the bandage, passing around the limb and splint, would exert traction upon the fragments in such a manner as to draw them together. The splint was well padded, so as to fit the limb comfortably, and the bandage was applied as on page quoted above; "a roller, made of unglazed cotton cloth, is then turned around the leg and splint to within about three inches of the knee and another from the upper end of the splint, over the splint and thigh, to within three inches of the knee. While an assistant approximates the fragments with his fingers, the surgeon makes two or three turns with a third roller around the limb and splint, close above the knee; after which the roller descends below the knee, and an equal number of circular turns are made close below the lower fragment of the patella; and finally, a succession of oblique and circular turns are made above and below the fragments, which turns are to approach each other in front until the whole of the patella is covered, the last turn being again circular. The dressing now being completed, the rollers are carefully stitched to the cover of the splint, through its whole length, on both sides, and the limb is left supported in the elevated position by a suspending apparatus, or by some other mode which will insure its maintenance in this position." I quote the above for the reader to understand that all Dr. Hamilton's details were carried out, with the exception of the substitution of a pine board for a splint, instead of shellac cloth. This treatment was kept up for a week, but the effusion and swelling not dimin-

ishing, I applied a Martin's rubber bandage, instead of the cotton one, from the ankle to the gluteal fold, expecting to get absorption of the effused fluid, and also by the constant elastic pressure to overcome any tendency to spasm in the quadriceps muscle. I had intended to remove the fluid from within the joint with the aspirator, before applying the bandage but having removed the bandage from another patient just before calling to see this one, and not having the aspirator with me, I concluded to apply the bandage, as I had it with me, and if necessary aspirate the next day. When I came to see him the next day the swelling had subsided so much, and he was feeling so comfortable that I decided not to aspirate. From this time on he made a speedy recovery. At the end of nine weeks I let him get upon his crutches, and to-day he walks well on the limb, although there is yet considerable stiffness of the joint. The union is so intimate that it is with the greatest difficulty that the site of the fracture can be made out.

Fracture of the Elbow-Joint—Recent Subjective Nervous Symptoms.

Dr. E. L. KEYES presented before the New York Surgical Society a patient to demonstrate the perfect function of an elbow-joint, badly fractured during childhood, and still ununited, and exhibiting evidences of failure of nutrition, and subjective nervous symptoms after quite recent active use. The patient, a man twenty-two years of age, had, when about five years old, received a fracture of his left elbow. From this he recovered, and the joint, arm and hand, gave him no inconvenience for about fifteen years. He had been able to follow the business of a traveling salesman. And all the motions of the forearm were equal with those in the uninjured limb.

About one year ago he changed his occupation, and was more or less engaged in the active exercise of opening oysters. He soon began to suffer from pain in the left forearm, had a sensation of coldness along the course of the ulnar nerve, and soon afterward it was noticed that some of the muscles of the hand had diminished in size. When Dr. Keyes examined the arm he found that the external condyle had been fractured, and remained ununited, a certain amount of outgrowth of bone had occurred; and there was a partial dislocation outward of the external condyle, carrying the head of the radius with it. There was no atrophy of the muscles of the forearm, but the limb was of late numb and painful. There was atrophy of the interossei of the left hand, and particularly of the adductor pollicis. The subjective symptoms, as well as the atrophy, had developed within the last year since he had submitted the arm to more active exercise than formerly, and the question was whether anything could be done which would be likely to arrest the atrophy and restore the sensation of the arm. He had advised cessation from all active exercise of the hand and forearm together with the use of electricity. —*Med. Record.*

Fracture of Clavicle Treated without Apparatus.

Dr. H. R. PORTER, Bismarck, D. T., communicates the following: "The case of fracture of clavicle, treated without apparatus, reported in *Medical Record* of March 4, 1882, by Dr. Newton, U. S. Army, prompted me to report the following case, which occurred in the same month, and about the same time last January.

"Dr. S——, while making a night visit, fell off the sidewalk, a distance of

about three feet, fracturing the left clavicle near the middle.

"I was called in the morning and found the parts tender, swollen, and painful, and the doctor *very irritable*. I proceeded to put the fractured ends of the bone in place, and to apply the old wedge-shape pad, etc., when the doctor coldly informed me that he would not have any apparatus, that the least touch hurt him, and he would let it go without any dressing. I told him that he was the judge and knew the consequences, and left him. Nothing was done in the case. He wore a large overcoat without putting the left arm in the sleeve, and simply did exactly as the case reported by Dr. Newton, viz. :

"He merely favored his left arm by carrying his hand in his breast ; he did not use a sling." In about four weeks the bones were firmly united with but very little overlapping. The result was as good as is often met with when the best apparatus is used by the ordinary practitioner, or, perhaps, the skilful surgeon. I met the doctor every day during his treatment of his fracture. He was very careful to walk on smooth ground, and the left arm received no unnecessary motion, and *no treatment*. The doctor remarked that he had made worse jobs than that on other people, and I believe I have too."—*Ibid.*

A Contribution to the Treatment of Fractures of the Thigh in Childhood.

In the *Berliner Klinische Wochenschrift*, JACUBASCH published an adverse criticism on the treatment of fractures of the thigh in very young children by vertical extension of the limb, claiming that this method was often productive of a fatal result by reason of hypostatic pulmonary affections. According to Kummel this accident is more

imaginary than real. It was not met with in any of the forty cases treated by vertical suspension under the charge of Schede and Martini. In other respects the method, he thinks, is far superior to any other plan of treatment. It was applied in all cases of simple fracture of the thigh occurring in children under two years of age ; in older ones only when horizontal extension had to be abandoned because of frequent and unavoidable soiling of the dressings by excrement. The results were invariably good. In only one instance was shortening detected, and this did not exceed one centimeter. On the contrary, a lengthening of the fractured extremity to the extent of one to at most two centimeters was observed a few times, but this elongation disappeared soon after the patients recommenced to walk. Although it might have been *à priori* supposed that rotary dislocation would be likely to occur, this was not the case in any instance, even when the children were very active. In otherwise healthy and well-nourished children consolidation was usually sufficiently firm after the lapse of three weeks to allow of the removal of the apparatus. In rachitic or otherwise debilitated patients consolidation was delayed for a period of ten to twelve weeks or longer. The method of extension was the ordinary one, namely by strips of adhesive plaster, not passing above the point of fracture, and retained in position by a flannel or other roller bandage.—*Ibid.*

Fracture of the Patella.

Dr. POINSOT (*Revue de Chirurgie*), comes to the following conclusions respecting the treatment of fracture of the patella : First, the joint should be immediately punctured in all cases where there is much effusion into its cavity ;

subsequent drainage is not necessary. Second, subsequent to the puncture and where coaptation of the fragments is with difficulty obtained, Kocher's suture of the patella should be practiced. Third, the apparatus should be frequently examined while articular swelling exists. Fourth, an apparatus limiting flexion should be worn several months after union has taken place. Fifth, opening of the articulation, with osseous sutures, is indicated in cases where puncture fails to remove the exudation. Sixth, it is also indicated in cases where an excess of callus interferes with the motion of the joint, and in pseudarthroses.

Resection of a Portion of the Stomach.

The operations of BILLROTH and WOLFLER on the stomach have attracted considerable attention to the surgical affections of this organ (fibrous tumors, foreign bodies, etc.) and a number of other surgeons, among whom may be named Péan, Langenbeck, Rydger and Forelli, have opened the stomach with the scalpel.

The following observation by M. Cavazzini in *Gaceta Medica Provincie Venete*, 22d year, is interesting, and has the merit of priority, as the operation was performed in 1874.

A woman, 27 years of age, suffered for over a year from pain in the epigastric region, with vomiting. Directly over the stomach, seemingly in the abdominal parietes, but not adherent to the skin, was discovered an indurated mass, from three to four centimetres in diameter. It appeared to be a fibro-cartilaginous body situated in the abdominal parietes, behind the fascia superficialis, in front of the peritoneum.

As irritating interstitial injections and other forms of treatment remained with-

out effect, and the patient was sinking, it was decided to extirpate the tumor.

During the operation it was found that the tumor reached the walls of the stomach, rendering it necessary to penetrate the organ in order to remove it completely. Sutures were applied, but on the tenth day some of the contents of the stomach escaped at the wound; however, notwithstanding a slight erysipelatous attack about the opening, the patient entirely recovered in about two months.

The patient died of consumption five years later, and at the autopsy the fundus was found drawn upward and toward the left, under the diaphragm. The pylorus was adherent to the parietal peritoneum. Cicatrization of the wound was complete.—*Med. & Surg. Reporter*.

Surgical Expedients in Emergencies.

Dr. R. I. LEVIS (*Ibid*):

The relief of an over-distended bladder I have effected by doubling a piece of common iron bell wire, and the blunt doubled end passed through the urethral tract, distending it and allowing the urine to pass between the wires.

A common rye straw, with its end wrapped with either thread or yarn, or tipped with sealing wax, or the stem of a common clay tobacco pipe, are efficient substitutes for the female catheter.

Venesection can be made easy and certain, with even a dull and blunt pocket knife, by first transfixing the vein with a fine sewing needle.

A number of ready and ingenious resources are given for the arrest of epistaxis and hemorrhage in general. A good tenaculum is extemporized from a fish hook tied to a pen-holder. A flannel bandage, cut bias, is sufficiently elastic to substitute the Esmarch bandage.

Expedients for ready fracture dressings are given, one of the best of which is the material of common palm leaf fans, split into fragments and bandaged around the limb. For a ready fixed dressing the ordinary sand-paper, softened in warm water, is recommended, the paper, sand and glue giving, when dry, the requisite stiffness and body to the splint.

Postural methods of treating fractures, as those in the vicinity of the joints, are referred to, and that of the clavicle by a brief recumbent position.

To open the mastoid cells in cases of abscess urgently threatening cerebral complication, he has effectively used a carpenter's gimlet.

Rectal injection by a hydrostatic column, with a long tube, is referred to; and also the distention of the lower bowels, in cases of invagination and impaction, by carbonic acid gas and water from the ordinary mineral water bottle, or the syphon attached to a rectal tube.

Stramonium is recommended for ready use in iritis and traumatic injuries of the eye when atropia is absent.

For simple, cheap and effective antiseptics, sulphurous acid, alcohol, whisky, and the salts of iron, copper and zinc, may well substitute carbolic acid.

Glycerine in Burns.

Dr. JOHN B. C. GUZO (*American Medical Weekly*), says that he has used glycerine pure or with equal parts of water, according to the nature of the burn, applied on linen compresses, constantly applied as a lotion to the injured surface. He has also had recourse to a mixture of glycerine and collodion, in the proportion of one part of the former and three of the latter, applied with a camel's hair brush, which has been used in several cases with good results. This preparation is exceedingly supple, does

not crack nor scale off from the skin and accommodates itself to muscular action and the movement of the limbs. The results of the application of glycerine in this manner have convinced him that it has some specific action in expediting the cicatrization of burns and scalds, however extensive they may be, and that it prevents in a great degree the unsightly puckering and contraction, which too often interfere with the proper action of joints involved in the accident.

—*Chic. Med. Review.*

Treatment of Bullet-Wounds.

In a report made to the Societe de Chirurgie relative to fractures by pistol balls (*Cincinnati Lancet and Clinic*), Dr. VERNEUIL declares that for ten years he has always abstained from intervention in wounds and fractures produced by firearms, and he has always been fortunate in this abstension. He is altogether of the opinion of those who think that the part in which the wound or fracture is situated should be immobilized as far as possible, and no attempt made to find the missile. In regions where this immobilization cannot be affected in a perfect manner, as in the chest or abdomen he applies upon the wound a bit of collodionized gauze, and surrounds the region with a bandage agreeably tightened. Drs. LeDentu and Chauvel expressed similar views.—*Ibid.*

Inoculation as a Prophylactic Measure Against Malignant Pustule.

In a communication to the Paris Académie des Sciences, M. E. CORSON recently described a case of malignant pustule, occurring in the person of a man who had experienced one attack of that disease twenty-seven years before. The symptoms were of a very grave char-

acter, embracing severe febrile phenomena and deep coma, which persisted for more than twenty-four hours. The patient, however, made a rapid recovery and, at the end of a few days, bore no marks of the disease except two ulcerations upon the back of the hand. M. Corson advances the theory that the rapid recovery of the patient may have been due to the possible modifying effect exerted by the former upon the latter attack.—*France Médicale*.

Clinical Notes of two cases of "Tumor," with Illustrations.

D. MACLEAN, M. D., Ann Arbor, Mich. (*Canada Lancet*.)

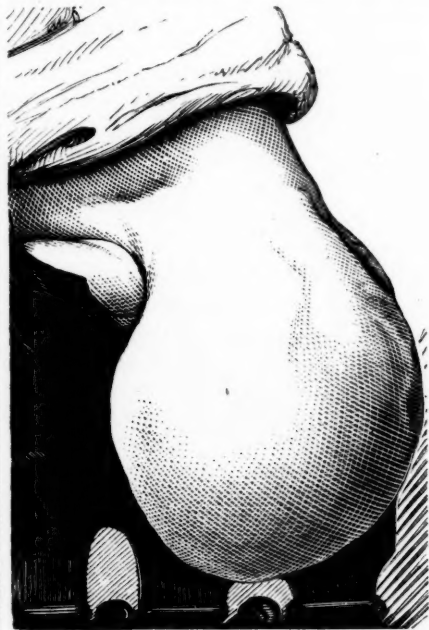
CASE I.—J. H. S. æt. 57, of Milan, Mich. Patient came to the clinique June 4th, in the hope of having a tumor, which had long been a great burden to him, removed. He stated that the tumor first appeared twenty-two years previously in the region of the groin, and that it had gradually altered its position until it reached its present situation as shown in the accompanying cut. It will be seen that the tumor is attached by a broad base, and hangs over the left hip, the pedicle being nearly related to the crest of the ilium. Patient had no theory as to how or why the tumor had changed its position, but he was quite positive as to the fact of the change having occurred. The tumor measured twenty-eight and a half inches in circumference, and extended from the crest of the ilium to the middle of the thigh. It was not painful, but its weight caused serious inconvenience, to relieve which it was supported in a sac suspended from the opposite shoulder. During the last seven years the growth of the tumor had been much more rapid than formerly.

On examination, the tumor was found to be irregularly lobulated, solid, and

very vascular. Enormous veins were visible on its superficial aspect.

Patient was extremely anxious for an operation, and as his health otherwise was good, and no contra-indication existed, I agreed to remove it.

Chloroform having been administered, I first transfixed the base or pedicle with a strong double ligature, in the hope of thereby controlling hæmorrhage. It at once appeared, however, that no material



advantage could be gained in this way. I then tried to empty the tumor of its blood by Esmarch's bandage applied to the growth itself. This expedient proving equally futile, I took an amputating knife, and all hands being on the alert for hæmorrhage, with one sweep I divided the pedicle completely. Notwithstanding the fact that the track of the knife was instantly covered by compressing sponges, one gush of blood occurred, sufficient to blanch the patient and give him a very cadaverous appearance.

All bleeding points were ligated by cautiously exposing the surface of the wound in small sections. The lips were then approximated by a few stitches, and water dressing applied.

The symptoms of shock were very decided but not alarming, and patient made a rapid recovery, and was dismissed, *cured* June 14th, just ten days from the date of operation. Three years have now elapsed since this operation was performed, and it is satisfactory to be able to report that up to the present time the patient has enjoyed excellent health, and as yet no symptoms of return have appeared.

The structure of the tumor was fibrous, degenerating at some points into fatty. Its weight, immediately after removal, was thirty-three and one-half pounds.

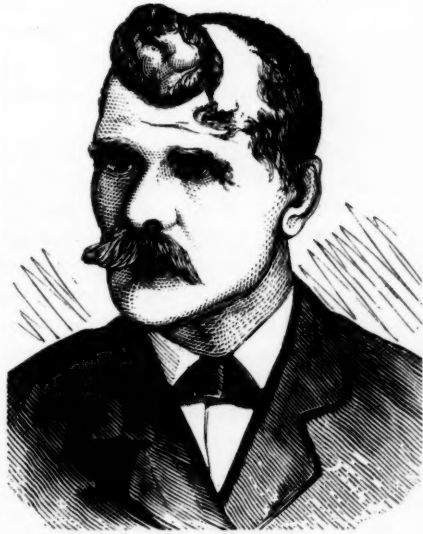
CASE II.—J. C., æt. 44, of Jackson, Mich. Admitted to the University hospital January 23rd, 1882, on account of a tumor of the forehead. The situation and relative size of the growth is well shown in the accompanying woodcut, copied from a photograph from life.

History.—Patient states that eight years ago a small lump, about the size of a peanut, was noticed over the vertex. After a blow this little tumor became irritated and grew rapidly, until it attained the size of a peach. It was then excised by a surgeon in Jackson, but before the wound healed, the tumor reappeared at the anterior margin of wound, and grew rapidly. This was two years ago. One year ago a second operation was performed by another surgeon in Jackson, but with no better result. By this time the tumor had developed in a direction towards the forehead, leaving the original site entirely free from disease.

On examination, the tumor was found to be firmly attached on its deep aspect.

The superficial surface was ulcerated, and poured forth a pretty profuse discharge, composed apparently of water, pus and blood. The skin over the growth was disorganized and could not be utilized to close the gap made by operation.

Patient being a stout, vigorous man, in good health in other respects, and with a good family history, and being greatly alarmed about the tumor and willing to submit to any risk in the hope of being relieved of it, I determined to operate. I took occasion to point out to



the class two serious dangers which had to be encountered. 1. The danger of speedy return owing to the malignant appearance and history of the growth; 2. The danger of osteitis, meningitis, etc., owing to the necessity of removing the pericranium, in which tissue it seemed most likely that the morbid structure had originated. Still, I had no hesitation in recommending the patient to take his chance and have the operation performed, and to this he eagerly assented.

Jan. 26th.—Chloroform having been given, I first of all removed the growth by a circular incision right down to the

bone. I then peeled off the pericranium as far as it was exposed; and, finally, I applied pure chloride of zinc to the osseous surface.

A large number of vessels bled, and were secured by catgut ligatures. No attempt was made to close the gap, which was left to heal by the efforts of nature, aided afterwards by the introduction of many skin-grafts. The after treatment consisted in simple dressing to the surface of the wound, and its careful protection by cotton wadding. The bone at first appeared white and dead, but gradually points of granulation appeared and increased till the white surface presented the appearance of a healthy, healing sore.

Feb. 2d.—Patient complained of a very severe pain in his head, and mercury was at once prescribed. The headache was relieved in a day or two, but it was not until the 22d Feb. that it disappeared finally. At this time, also, a very thin layer of dead bone was floated up on the surface of the granulations, and was lifted off with the dissecting forceps.

March 3d.—Wound nearly cicatrized, the islands of grafts having grown together all over the surface. Dismissed cured.

April 17th.—Latest reports from patient completely satisfactory in all respects.

The specimen was sent to the histological laboratory, and was carefully investigated by Prof. Stowell, who found the structure to be that of "*spindle celled sarcoma*."

Carbuncle—Its Treatment.

Dr. J. B. RICHARSON, (*Can. Med. Record*.) Sidney Ringer (*Handbook of Therapeutics*) asserts, "Belladonna applied over abscesses and carbuncles reduces inflammation and allays pain." He advises its employment in any stage

of inflammation, as "it will often arrest the progress of an abscess otherwise almost certain to maturate." Even when it fails to prevent suppuration "it will reduce inflammation, subdue much of the pain, and greatly limit the inevitable abscess."

As regards the use of poultices in these cases, my experience will not allow me to indorse their employment; for I am convinced they not only cause the formation of boils around the seat of the carbuncle, but produce an extension of the destruction of both integument and underlying tissues. I therefore never employ them.

When first seen, and recognized to be a carbuncle in its formative stage, make a small opening with a sharp-pointed bistoury in the center of the swollen and inflamed structures just large enough to allow the easy introduction of the nozzle of a hypodermic syringe, which has been previously charged with a fifty-per-cent. solution of carbolic acid in oil or water, and after passing it a short distance into the central-forming slough, press the piston sufficiently to expel a drop or two of the contents of the syringe; retract and deflect the point of the syringe as you re-introduce, and repeat this until you have insinuated the solution into a considerable area of the interior of the commencing carbuncle. This done, with gentleness and patience rub into the overlying skin, upon and for a considerable distance around the forming anthrax, equal parts of extract belladonna and glycerin (Price's), finally applying a piece of lint well smeared with the same solution to the parts, strapping it in its proper place with gum-plaster, and over all this dressing a well-worn, soft silk handkerchief (folded). This external dressing should be repeated twice or oftener daily, with the double object of cleanliness and to

get the supplying vessels impressed physiologically by the belladonna externally applied. As soon as the point of destruction of the integument is sufficiently large—or you are able to enlarge it by use of scissors or forceps and not cause great pain or hemorrhage—a piece of lint saturated in a fifty-per-cent. carbolic-oil solution should be gently but firmly introduced into the opening, and, by spreading it out, be made to come in contact with the bottom of the inner surface of the carbuncle. This application causes at first some pain, but it will be short-lived, the patient soon appreciating the anesthetic effect of the carbolic acid. Upon the first piece of lint place a second piece (dry), and cover all with a third larger piece (three inches square), the inner surface of which has had a good coating of the belladonna-and-glycerin solution applied to it, securing the last with strips of plaster as before mentioned. At each succeeding dressing, as slough forms or breaks down into pus, remove carefully with forceps and scissors as much as you can, causing no bleeding, and as you approach the healthier parts beneath lessen the strength of carbolicized oil or watery solution of acid you employ until you dilute to five grains to the ounce; finally discarding altogether the acid solution, substitute for it either lukewarm water as a dressing, or, if indicated, a weak astringent solution. The carbolic acid has the effect of stimulating the circulation of the parts involved in the diseased action with which it is brought in contact, thus enabling them to repel this tendency to slough. It acts as a local anesthetic, together with the external application of the belladonna, removes to a great extent the usual necessity for the internal administration of sedatives to obtain sleep, and lessen pain. The glycerin and oil

exclude the atmospherical air, thereby partly removing one necessary factor to the production of decomposition. The antiseptic and antiputrefactive quality of the acid reduces the danger of pyemic symptoms as a resulting complication to a minimum.

Treatment of Abscess of the Liver.

DR. RANDOLPH WINSLOW, in *Annals of Anatomy and Surgery*, contributes an excellent article on this subject, and closes his paper with the following conclusions:

1. The liver should always be aspirated in a case of suspected abscess, in order to verify the diagnosis.
2. Many small, and a few large abscesses, have been cured by one or more aspirations; hence this method should always be employed at the first exploration, and we should then wait until it refills. If the pus collects slowly and in small amounts, it may be again aspirated; if quickly, and in large quantities, aspiration is not to be relied upon.
3. Incisions should be made into the abscess cavity at the most prominent portion of the tumor, whether in an intercostal space or not; and irrespective of the presence or absence of adhesions.
4. Rigid antiseptic precautions add much to the safety and certainty of a successful result.
5. When Listerism is impracticable, good results will be generally obtained by simple incision, or puncture by a trocar and canula, followed by the introduction of a drainage tube, and the daily use of carbolicized injections.
6. Any of these methods are preferable to leaving the case to nature.—*American Medical Weekly*.

Extirpation of a Pulmonary Hernia.

M. DE LOS MOZOS reports an interesting case in the *Revista de medicina y*

*cirurgia practica*s. A young man, 17 years of age, received, in a fight, a large stab wound, three centimeters in width, between the fifth and sixth ribs, on the left side, and through it protruded a portion of the lung as large as a small orange.

The patient was pale, almost in a state of collapse, with filiform pulse, and suffered from incessant coughing, with sanguinolent expectoration; he could lie only on the right side. After forty-eight hours, however, his condition improved wonderfully, and remained so during the following days. As the portion of lung protruding could not be reduced, the physician in charge fearing mortification, extirpated it entirely, applying the actual cautery to arrest hemorrhage.

The patient made an excellent recovery, the wound cicatrized well, and no deformation of the thoracic parietes or alteration in the respiration ensued.—*Med. and Surg. Reporter*.

Treatment of irreducible and Strangulated Hernias by Morphia hypodermically administered.

Le Gazette des Hôpitaux, presents a summary of the results obtained by Dr. PHILIPPE in the treatment of five cases of irreducible or strangulated hernia by means of hypodermic injections of morphia, and concludes that this method constitutes a potential expedient to which the surgeon should resort before adopting operative measures. Dr. Philippe's first case was one of double irreducible inguinal hernia. Taxis was first employed, for a quarter of an hour, without result. Five drops of a morphia solution, containing about nine and one-half grains to the ounce, was then injected, hypodermically, after which the volume and the tenderness of the hernial tumor dimin-

ished. Fifteen minutes later another injection, of five drops, was administered, and the reduction of the hernia was easily effected. The other cases only differed from the first, as regards treatment, in the amount of morphia used. One of the cases was an umbilical hernia, one was a strangulated femoral, and another a strangulated inguinal hernia. Reduction was easily effected, in all the cases, after the employment of from two to six injections.—*Med. Record*.

Heaton's operation for the radical cure of Hernia.

The Heaton method consists, as is well known, of irrigating the inguinal canal and rings with a preparation of white oak bark in solution. The fluid recommended is composed of white oak bark in solid extract, fourteen grains in amount, to which is added half an ounce of the fluid extract of the same drug. The two are then gently heated together. The mixture is thick and muddy, and requires shaking before it is used.

The operation is thus described by Dr. George W. Gay, one of the surgeons of the Boston City Hospital: Having reduced the hernia and if possible the sac, an instrument resembling the hypodermic syringe is charged, and then thrust directly through the skin into the external abdominal ring, the point of the needle then being carried up the inguinal canal in front of the spermatic cord, as far as the internal ring. The fluid is deposited slowly while withdrawing the instrument, the point of which is to be moved about in all directions, in order that the astringent may be evenly distributed throughout the canal. A compress and bandage are then immediately applied, and they should be worn for some weeks. If the operation prove successful, nothing further is re-

quired to be done. The object is to set up a moderate inflammation, for anything like a severe reaction prolongs convalescence and adds nothing to the success of the operation. It is intended in the operation to bathe the fibrous structures in contact with the neck of the sac, but in many cases it is by no means certain that the needle does not enter the perineum. At any rate, in Dr. Gay's experience (23 operations in 15 cases) peritonitis has never resulted. Of the total number, a cure is recorded in 4, relief was given in 8, and there were 3 failures.

A part of this non-success is attributed either to a lack of skill or experience in the operator, to imperfect after-treatment, or finally the unwillingness of patients to undergo the secondary operation which is often necessary.

Taking inguinal hernia alone as a test for the method, it is thought to be safe, comparatively easy of performance, and attended with little pain or danger. In a certain number of cases it will cure, especially when the rings are small, or where, as in children, nature is attempting to correct the vicious condition of the part, but needs a little assistance.—*Boston Medical and Surgical Journal, Ibid.*

Hypodermic administration of Carbolic Acid for the cure of Ulcers, Poisonous Bites, Hæmorrhoids, Carbuncles and Tumors.

DR. N. B. KENNEDY read a paper on the above subject recently, before the Texas Medical Association in which he strongly advocates the use of carbolic acid *hypodermically* in the diseases mentioned, and cites several successful cases, of some of which the following are short abstracts:

Case I. Mrs. McC., suffering from large hæmorrhoids: five drops of undi-

luted carbolic acid was injected into the centre of the tumor. Pain was momentary. Four injections effected a complete cure.

Case II. J. D. R., suffering from carbuncles in back of neck, had not slept for five days and nights. Five drops of carbolic acid was injected into each of the carbuncles with the happiest results. *Rest* immediately followed, from which he *awoke refreshed*. A complete cure followed in three weeks.

Case III. Was called to see a boy ten years old who had been bitten by a rattlesnake in the dorsum of the foot. The foot and leg were livid and much swollen. I immediately injected five drops of the acid as near the bite as possible. Relief from pain was immediate. Swelling rapidly disappeared and recovery followed.

Case IV. J. F. L., farmer, had a painful tumor on back of his neck. I found a fibro-cellular tumor about the size of a small egg and injected about twenty drops of undiluted acid into the centre of the tumor, which in this case suppurated, but in ten days had entirely disappeared and left no cicatrix.

I have applied a fifty per cent. solution of carbolic acid to an ulcerated os with good result, also in cases of felons, as a local anaesthetic, undiluted, preparatory to incision.

DISEASES OF THE EYE AND EAR.

Iodoform in Ophthalmic Surgery.

Dr. KARL GROSSMAN, Stanley Hospital, Liverpool (*Ophthalmic Review*), says that iodoform seems to be of the greatest value in purulent conjunctivitis both of simple and virulent nature. Even those cases, in which infection has taken place and is already developed to its full height, may be checked by it.

Mercuric Cyanide in Ocular Syphilis.

Dr. GALEZOWSKI (*Le Progrès Médical*), claims that hypodermic injections of mercuric cyanide have a special action in ocular syphilis, not only local but of cerebral origin. The drug is given in injections of from five to ten milligrammes, carefully watched. Among the affections in which Dr. Galezowski has had good results from mercuric cyanide, are syphilitic iritis with corneal infiltration, syphilitic iritis with punctate keratitis, irido-choroiditis and punctate keratitis, and syphilitic atrophy of the optic disc.—*Chicago Med. Review*.

Treatment of Scrofulous Ulcers of the Cornea.

This is a form of keratitis which often comes under the care of the general practitioner, and as injudicious treatment may lead to the formation of opaque cicatrices, the following recommendations regarding treatment, made by M. Dehenne in *Le Progrès Médical*, may prove of service :

1. Instill daily into the eye four or five drops of the following collyrium :

R. Atropiæ sulphat, (neutral), gr. j.; aquæ destillat., f 3 iiss. M.

2. Abstain from every form of metallic collyrium, which often leave indelible marks, veritable metallic leucomata. Do not use any collyrium containing eserine, for affections of the cornea are frequently accompanied by iritis, and there would be danger of formation of posterior synechiæ.

3. Each evening insert between the eyelids, with a small camel's hair pencil, a portion, about as large as a pea, of the following unguent :

R. Hydrarg. oxid. flav., gr. xv.; ung. petrolei, 3 ss. M.

4. Apply four times daily over the eye compresses soaked in warm chamomile tea.

5. Administer a tablespoonful of cod-liver oil every morning.—*Med. & Surg. Reporter*.

VENEREAL DISEASES.**Iodoform for Soft Sores.**

In the *British Medical Journal* Dr. WALTER WHITEHEAD says that iodoform appears to be one of the most efficacious drugs in the treatment of the syphilitic non-infecting soft sore, when not unduly inflamed. It has, however, the unfortunate counterbalancing disadvantage of attaching to the patient the liability of unenviable suspicion, the public having become keenly alive to its distinctive and penetrating odor, and having also acquired an appreciative knowledge of the principal purpose for which the drug is most frequently used. He has succeeded, he thinks, in obviating this objectionable feature, without, apparently, sacrificing any of the therapeutic advantages of the drug, by using it in the following manner : He first very carefully cleanses and dries the sores by means of little pledgets of bibulous paper, and then, by means of a camel's hair pencil, applies freely over the surface of the sores a solution of iodoform in ether. The ether rapidly evaporates, and leaves the iodoform uniformly spread in an impalpable powder over the sores. To insure a free application, the latter part of the process may be repeated and allowed to dry. When perfectly dry each sore is given a coating of collodion, which is allowed to overlap, about a quarter of an inch, the area of each sore. Before the collodion has had time to dry, a pinch of absorbent cotton wool is placed on each patch as a protection against the rough contact of clothing. This dressing is allowed to remain undisturbed for twenty-four hours, when the firm film which forms

may be gently removed and a fresh coating applied. This treatment is continued day by day until all the sores have quite healed. He has found that a piece of gold beater's skin may be substituted for the collodion after the application of the iodoform. This process will suppress the odor, while a further advantage will be gained in the protection afforded by the collodion against auto-inoculation, and also against the risk of contagion from others coming in contact with the sores.—*Med. & Surg. Rep.*

Hypodermics of Mercury in Syphilis.

Dr. RAVOGLIA (*Cincinnati Lancet and Clinic*) concludes concerning these that: First. The subcutaneous method is the most easy treatment for syphilis. Second. That the best solution is one gramme of sublimate in one hundred grammes of water, one injection of one gramme of the solution every two days. Third. That the proper place for injection is the region of the glutei muscles not very far from their insertion in the iliac bones. Fourth. It is necessary to insert the needle horizontally in the muscular mass in its whole length. Fifth. No abscess or any other resulting irritations have been observed. Sixth. Twenty to thirty injections are necessary in a common case to complete the cure.—*Chic. Med. Rev.*

Subcutaneous Injections of Iodoform in Syphilis.

The *Centralblatt für die Med. Wissenschaft.*, No. 44, reports that Dr. THOMANN, having observed the good results attending the external use of iodoform in the treatment of certain syphilitic manifestations, was led to try if similar benefits could not be derived from it in the form of subcutaneous injections. He made use of a solution containing 3 iss. of iodoform to f 3 v. of glycerine,

and commenced with doses of grs. ivss; finding that these were well tolerated, he gradually increased them to grs. xj. He selects, in preference, recent cases in which sclerosis has not as yet caused irreparable disorders in any of the organs, especially in the lymphatic ganglions.

After ten or twelve injections, made on different parts of the body, he has observed a marked retrocession in the symptoms. No abscesses were formed, and only among a few patients were the injections followed by a slight sensation of pain, which, however, soon disappeared. The solutions used should always be freshly prepared.—*Med. and Surg. Reporter.*

Colles' Views Respecting Syphilis.

Dr. McDONNELL (*London Med. Record*) gives the following as Colles' principal discoveries in syphilis:

1. He establishes the opinion that secondary symptoms are capable of propagating the venereal disease.
2. While showing that a child may receive the infection of syphilis by sucking a nurse affected with secondary symptoms, he cannot recollect a case in which the diseased nurse infected the child unless she had an ulceration of the nipple.
3. He makes the important generalization (which Hutchinson has termed Colles' law) that a father cannot transmit syphilis to his offspring without implicating its mother.

Colles also draws a distinction between the local ulcer and the infecting chancre, contrary to the teaching of Hunter and other authorities of the period.—*Det. Clinic.*

Treatment of Tertiary Syphilis.

R. Potassii iodid., 3 vss.; hydrarg. biniodide, gr. ij.; aquæ distillatæ, 3 x.

M.—Tablespoonful to be taken morning and evening.—*M. Hardy, La France Med.*

Chordee.

M. COMBILLARD recommends (in *C. Courrier Medical*) to calm the pain induced in gonorrhœa by continued erections and chordee, injections containing bromide of potassium. These injections are not in any way irritating; they may be made four times daily, the last just before bedtime. The liquid should be allowed to remain one or two minutes in the urethra, in order to have the desired effect. The following is the most convenient formula:

℞. Potass. bromid., ʒjss., tr. opii, ʒss; glycerinæ, ʒij; aquæ, ʒv. M.

In fifteen out of eighteen cases there was rapid diminution or complete suppression of the erections. Bromide of potassium gives these happy results, no doubt owing to its anaesthetic influence in certain mucous membranes in moderating their reflex excitability.—*Med. and Surg. Reporter.*

Gonorrhœa.

DR. W. T. PARKER, (*New Eng. Med. Monthly.*)

℞. Zinci sulpho-carbolat, ʒj; mucil. acaciæ, ʒj; ext. opii aquæ, ʒj; aquæ, ʒvj. M. Use as injection night and morning.

Yerba Rheuma in Gonorrhœa.

It has been claimed that this plant, (*Can. Pharmaceut. Jour.*) has in all catarrhal discharges of mucous surfaces been found of value. After the subsidence of the acute stage of gonorrhœa, free injections of two ounces of the fluid extract, to a pint of water are claimed to yield very good results. This plant is claimed to contain an unusual quantity

of sodium chloride, but this can have but slight influence in producing the therapeutic properties which have been claimed for it.—*Chic. Med. Review.*

Chronic Gonorrhœa.

J. FERGUSON, B.A., M.B., Glasgow, (*Can. Jour. Med. Sciences.*)

Mr. A. J. took very sick one morning and sent for me. He gave me his age as 19 years, which I think was about correct. His temperature was 103°F.; pulse 101 per minute. There was a good deal of tenderness in the left iliac region. I found, on inquiry, that he had been afflicted with gonorrhœa for nearly two years. During this time he had received his share of treatment. A few days previous to the date of my visit, he had been drinking some, though his habits are steady. This had set up an acute attack out of the chronic one already existing. I gave him a saline laxative and the following mixture:—Pot. bromidi. ʒiv., Tr. gelsemii, ʒii., liq. ammon. acetat., ʒii., aquæ ad ʒviii., ʒss. three times a day. In a few days he was out of bed and came to my office. He told me that the stream of water had been gradually getting smaller for a considerable time. I found there was commencing stricture, and that there had always been a thick mucous, and often a purulent discharge from the urethra in spite of medication. I at once adopted the syphon treatment. After the fourth day all discharge ceased; but washing of the urethra was continued for ten days, morning and evening. Catheters were then passed at each sitting daily for one week, ranging from No. 6 to No. 10. He has now been free from all trouble, both with regard to the discharge and threatened stricture, for a period of rather more than two months.

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Fracture of the Astragalus.

At a recent meeting of the Medico-Chirurgical Society, of Montreal, Dr. Shepherd, Demonstrator of Anatomy, McGill College, read a paper on a hitherto undescribed fracture of this bone, and exhibited three specimens, all of which were obtained from dissecting-room subjects. The portion fractured was the process external to the groove for the tendon of the flexor longus hallucis muscle, to which the posterior fasciculus of the external lateral ligament of the ankle-joint was attached. Dr. Shepherd thought that it was produced by extreme flexion of the ankle with a twist of the foot outwards, and was probably one of the lesions which occurred in severe sprain. He suggested that it might account for some of the cases of severe sprain which recovered with impaired movement of the joint. The union was fibrous. He was not able to produce the fracture experimentally. At a subsequent meeting, Dr. Shepherd showed a fourth specimen in which there was bony union. Unfortunately, there was no history of any of the cases.—*Med. News.*—*Chic. Med. Review.*

Treatment for Fracture of the Clavicle.

Dr. W. B. BRADNER, of Warwick, N. Y., writes:

"Believing that the list of clavicle-mending fixtures is not yet full, I will describe a method which, for all that I know, is mine; which at all events has given me great satisfaction. I place the

hand of the injured side upon the sound clavicle and fix it there firmly by adhesive straps. I then elevate the elbow (keeping it pressed snugly to the chest) until the shoulder goes 'upward, backward, and outward.' I then support the elbow in its position by a sling, and secure the sling from slipping by adhesive straps in lieu of tapes, the straps being applied to the skin of the back, sufficiently abundant to prevent all slipping or change of the position of the sling. The arm, forearm, and clavicle thus form an isosceles triangle, and when the elbow is raised the angle formed by the arm and forearm is widened, and the direction of the arm carries the shoulder to the desired position. Its ease of application, its comparative security from shifting, together with being as nearly comfortable as anything can be to a broken clavicle, added to the fact that the resulting deformity is next to nothing, induce me to submit it to the test of the profession."—*Med. Record.*

Corrugated Paper as a Splint.

Dr. WALTER PYE gives an account (*British Medical Journal*) of a new splint, which he has found of great value. Its most important feature is flexibility combined with stiffness. It is made of a material known as corrugated paper, and is very cheap and light. Dr. Pye says: "From the purely surgical point of view, I have found this corrugated paper extremely useful. It can be used in all those cases in which the expensive kettle-holder splinting has been employed, and makes about the best angular splint for the elbow I have ever seen. The commercial use to

which this paper is put is principally that of either packing wine bottles in cases, or else of enabling single bottles to be wrapped up in a parcel not indicating its contents." The corrugated paper thus used in surgery by Dr. Pye is of American invention.—*Chic. Med. Review.*

Emphysema Complicating Fracture of Clavicle,

Was observed by Giburt (*La France Médicale*). The lung was probably adherent at its apex from ancient pleuritis. The traumatism was violent and direct and the lung being injured by the fragments, the subcutaneous tissues became inflated. The emphysema gradually disappeared, and the fracture resulted in pseudarthrosis.

Case of Fracture of the Os Hyoides.

Dr. JAMES G. LA ROE (*Med. Rec.*)

On the 1st of February last, I was called to B. P. J —, aged twenty-seven, married, and an engineer by occupation. He is short of build and very thin, not weighing over one hundred and twenty pounds. To describe the symptoms of his ailment at that time is to tell of a slight tonsillar trouble, a condition of things to which he is very subject.

A gargle of chlorate of potash and tannin speedily solved the difficulty, and he ventured to return to his work. Exposure by working in a damp place brought on a violent attack of follicular tonsillitis. This proved very obstinate, but it finally yielded to repeated topical applications of ferri persulphatis.

Five-grain doses of quin. sulph. dissolved in two teaspoonfuls of the elix. prun. virg. was also given every four hours.

Although very weak, he determined to go to work on the Monday morning following. After a good night's rest he

arose early the next morning, and as he did so thought he would indulge in the luxury of a good "gape." But alas, as he "enjoyed" he felt something snap just below the inferior maxillary, and immediately thereafter felt a slight swelling at that point.

Thereupon ensued great pain, made more intense by attempting to swallow the saliva. My first thought, before examining him, was that the inferior maxillary had become misplaced, but a glance proved the incorrectness of my suspicion. He directed my attention—in a very languid voice and hard pressed for breath—to a small lump just below the inferior maxillary and on the exact point where he felt "something snap." It produced exquisite torture as I pressed. His face presented as distressed a look as I have seen in many a day. What was the trouble? During all my practice I had never seen a case like this. Memory, however, proved equal to the emergency, and it came back to me like a flash after a lapse of at least a dozen years. While a student at Bellevue, I remembered to have seen the duplicate of this. It occurred in the service of Professor Hamilton. The accident occurred in the same manner, though usually the result of direct violence. As, for instance, the grasp of a murderous hand or a blow to the same purpose. The question to be decided was: Is it a fracture or dislocation of the os hyoides? When I pressed the slight tumor and tried in different ways to reduce it, it would not "down." My patient would hardly allow me to touch it a second time. After a while, however, he grew reconciled to the inevitable, and I satisfied myself accordingly. A slight crepitus was apparent after a careful examination, and I came to the conclusion that the right cornu was involved. The fracture was evidently at the junction

with the body. I attempted to pass a probang into the pharynx, but my patient "gagged" so that I had to desist. I handed him a glass of water, and the first mouthful made him turn red in the face. He looked more distressed than before, if that were possible, as the water returned the same way it had come. It took him some minutes to regain his breath properly. I attempted to place my fingers in the mouth, in order to reduce the fragments—as recommended by Holmes—but met with poor success. I came to the conclusion to let well enough alone, in order to gain a little breathing time for both myself and patient. There was so little displacement that nothing could be gained by extreme measures. Holding the head backward and pressure by means of adhesive straps were alone recommended, and internally the usual astringents. Having no "œsophageal tube" handy, as suggested by some surgical authorities, I could not tell my patient to take his food that way. If need be, I determined to resort to the last mentioned mode of sustaining life. For the present, perfect rest alone was advisable, since he was in no danger of suffering from asthenia.

When I saw him the next day a little wine had passed his lips. He had managed to swallow it almost drop by drop. It was cruel torture to attempt anything of the kind, but he realized how necessary it was to quench his natural thirst at least. In order to see how it would work I asked him to swallow a little before me. He did so very slowly, and anybody who has seen a victim of hydrophobia when water is handed to him can imagine the result. There was a spasmodic action of the throat, an agonized face, and once, when a few drops more than usual had passed down, a rejection of the same. He pronounced

himself as completely discouraged at the prospects before him. Though usually having a good appetite, he felt comfortable without food for the first few days. As time went on he learnt the trick of holding his head in a certain position, thereby suffering less pain and absorbing more liquid nourishment. The position he assumed was downward and toward the right clavicle.

I attempted several times to pass the probang but found it impossible in view of the increased hyperæsthetic condition of the intestinal tract.

Different authorities assume that the head should be thrown backward, and, as mentioned above, this was ordered. At first I was a little adverse to my patient's use of his discovery, but he proposed to take all the comfort he could in his sore strait, and I could hardly blame him. In the end it proved all right.

At the end of two weeks the lump had grown the least bit smaller, but still the pain existed. For its moral effect I ordered a liniment composed of chloroform, tinct. opii. and lin. sapon, to be used four or five times a day. A couple of days later the soreness on the outside was reduced to a minimum, but it was fully three weeks before it had disappeared. Meanwhile the exquisite pain grew less when attempts were made at deglutition. Simultaneously, as might be supposed, with the disappearance of tumor the torture of the throat ceased to exist. It is true there was a slight soreness for a day or two afterward, but that was as nothing to what had preceded it. My patient did not seem to mind this trifle, but made haste to make up for lost time in exercising his gustatory powers.

It may be taken for granted that he presented a very emaciated appearance for the first few days of convalescence,

but in due season he gained the flesh he had lost.

The Successful Reduction of a Backward Dislocation of the Radius and Ulna Seven Months after the Injury.

GEORGE E. BREWER (*Med. Record*): Edward McCarty, aged twenty-one, of Crawford Co., Penn., in August last, received a fall which resulted in a backward dislocation of the radius and ulna. The injury was such as to baffle all attempts at reduction made by neighboring physicians. March 15, about seven months after the injury, he consulted Dr. Miner, who found upon examination that the dislocation was complete, both bones of the forearm being distinctly felt resting on the humerus about three inches above their normal position, the coracoid process of the ulna firmly imbedded in the olecranon fossa, and the arm immovably extended.

The patient was thoroughly etherized. Forcible extension was then made upon the arm. This was followed by an unsuccessful attempt at flexion, clearly showing further extension necessary, before flexion could be accomplished. The tendon of the triceps was now divided about an inch above its attachment to the olecranon. Very powerful extension was then made (the combined efforts of four men), this, with forcible flexion, pronation, and supination was continued for nearly three-quarters of an hour. Then measurement, the ease with which the arm could be flexed, and absence of deformity, all indicated that the dislocation had been successfully reduced.

The arm was dressed at right angles, without a splint, and the patient placed in bed.

March 17th.—Considerable swelling of the parts. Passive motion attended with pain. Pulse, 110. Temperature, 99°.

March 19th.—Patient sitting up. Passive motion. Pulse, 90. Temperature, 98.

March 22d.—One week after the operation. Motion without pain, but limited, owing to the œdematous condition of surrounding tissues. Patient left the hospital and went to his home in Pennsylvania, with every indication that complete recovery and good motion would eventually be obtained.

In these old dislocations of the forearm, especially where the displacement is considerable, the contracted triceps offers the chief muscular resistance to replacement.

Dixie Crosby, of New Hampshire, successfully replaced two old luxations of this kind by fracturing the olecranon. This method has also been successfully practised by Hamilton and others. Subcutaneous section of the tendon of the triceps seems to possess all the merits, while it lacks some of the disadvantages attending the fracture of the olecranon.

Sudden Dislocation of the Liver.—Recovery.

Dr. A. Y. P. GARNETT (*Am. Jour. of the Medical Sciences*), reports a case of sudden dislocation of the liver. A lady aged fifty, while stooping down hurriedly to pick something from the floor, felt a sudden wrench or giving away on the right side. Examination revealed a displaced liver reaching to the crest of the ilium. Much discomfort was experienced, but the patient was relieved by spontaneous reduction in the space of three days. A week's confinement in bed, followed by the use of a broad elastic band around the waist, constituted the remaining necessary treatment. The patient apparently regained to a great extent her normal condition and state of health.

Complete Posterior Dislocation of the Knee Joint, with Life-long Use.

Mr. J. BAGNALL OAKLEY reports and figures a case of the above injury in the *Lancet*. The patient, aged 70, when seen, stated that, when nine months old he fell and damaged his knee-joint, causing complete posterior dislocation. He has worked at brickmaking all his life, and has never been laid up on account of his knee. — *London Med. Record*.

Transplantation of Bone.

DR. MAC EWEN, of London: A child three years old was admitted into the Glasgow Infirmary for necrosis of the right humerus, the shaft of which was already separated from its head at the epiphyseal junction. Fifteen months after the necrosed portion had been removed there had been no bone formation of any account, and over two-thirds of the shaft was wanting. A first transplant of bone was then performed. In making the sulcus for the reception of the graft, reliance had to be placed on anatomical relations as to correct position, as there was no trace of periosteum or fibrous structure to indicate the former location of the bone. Portions of human bone were transplanted on three different occasions, the grafts being obtained from patients affected with anterior tibial curves, from whom wedges of bone had to be removed for the purpose of straightening their limbs. These osseous wedges were each divided into many small pieces, which were immediately placed in the sulcus in the boy's arm. The fragments united together, as well as adhered to the head of the humerus above and to the condyles below; ultimately forming a solid rod only half an inch shorter than the humerus on the opposite or left side. This transplantation of bone converted

a useless arm into a thoroughly useful one. Great stress was laid by the operator upon the subdivision of the transplanted bone into fragments, as thereby greater nourishment is able to be conveyed from the surrounding flesh to the osseous formation. The conclusions arrived at are that transplanted bone is capable of living and growing, and that such transplants are capable of being put to practical uses beneficial to mankind, but that to insure success the transplantation must be conducted antiseptically. — *Boston Journal of Chemistry*.

Anchylosis in Infantile Paralysis.

Some cases reported by Dr. ALBERT (*Lancet*) have excited a good deal of interest. Struck by the fact that many cases of infantile paralysis are condemned to the life-long use of complicated apparatus to compensate for the loss of rigidity in the lower limbs, he has attempted to increase the use of the legs by operation. He excises the knee and ankle-joints, and thus obtains bony anchylosis between the femur and tibia, and tibia, fibula, and astragalus. The rigid lower limbs in walking are swung forward by the abductor and great flexor muscles of the hip joint, which generally retain or recover their power. This treatment has already been carried out in four cases, and a fifth is now preparing for the performance of the operation. — *Chic. Med. Review*.

Excision of the Knee in Early Life.

Dr. WILLIAM STOKES (*British Medical Journal*), lays down the following propositions on the above topic:

1. Excision of the knee should not be looked upon as a last resource, but should be undertaken, if possible, before any profound organic changes take place

2. Expectant treatment to be efficient, must be undertaken at an early stage of the disease, and extend over a period of at least two years.

3. No better result than ankylosis can be looked for by this method.

4. In a patient with a predisposition to secondary tuberculous developments, the possibility of the recurrence of the disease after expectant treatment must be borne in mind.

5. In cases attended with prolonged suppuration, the chances of the occurrence of visceral, especially renal disease, must not be lost sight of.

6. Where the skin is unbroken, the disease limited, an efficient method of fixation applied, and a rigid system of antiseptic dressing of the wound adopted, primary union may, in the majority of cases, be anticipated.

7. When these latter conditions are fulfilled, excision of the knee-joint can not be longer regarded as the formidable procedure it was formerly held to be.

8. The alleged unfavorable results of excision of the knee-joint in early life are opposed to more extended clinical experience.—*Detroit Clinic*.

Osteotomy

Is indicated, according to PRADIGNAC (*El Genio Medico-Quirigico*): 1. In rachitic deformities of the inferior members during osseous eburnation, simple or cuneiform osteotomy should be practised in children of six to ten years. 2. Ankylosis of the lower jaw demands imperatively simple osteotomy by Rizzalli's method. In ankylosis of the hip in children it is contra-indicated by fracture of the neck of the femur. In the adult in case of inter-trochanteric or sub-trochanteric fracture, osteotomy may be performed. Ankylosis of the knee, with intimate, heavy

union, indicates the cuneiform variety the best method of treatment. It is also indicated in ankylosis of the ankle or tarsal articulations and fractures consolidated in a vicious manner, when extension or rupture has been unsuccessful. 3. Total osteotomy is preferable to partial in genu-valgum of adults. The operation should always be done under Listerian precautions.—*Chic. Med. Review*.

Influence of Antiseptics on the Periods of Amputation after Crushing Injuries.

Under this head the *Medical News* recently published an interesting clinical lecture by STEPHEN SMITH, M. D., of New York city. The lecturer presented a case of a boy who had, a few days before, entered the hospital suffering from a crushing wound of the leg, received by the wheel of a street car. The lecturer, by way of parenthesis, stated that in these injuries the wheel of the car seldom passes over the limb, but drags it along on the track, lacerating the tissues and breaking the bones, consequently the necessity in each case of determining by careful examination whether the wheel of the car passed over the limb, in which case amputation is inevitable, whereas if it did not, in the majority of cases the limb may be saved, but the special points desired to be impressed in the lecture are those in connection with cases in which there is a crushing injury, and amputation being necessary, as to the proper time and preparatory treatment, which is concisely expressed in the concluding resumé of the lecturer.

The lesson which I wish to impress upon your minds is this, viz.: In crushing injuries requiring amputation, treat the lacerated parts with carbolic acid water applied by means of irrigation, and delay the operation until the patient

is in a favorable condition to endure the shock. I need scarcely say that the same treatment should be adopted in similar injuries which do not require amputation, during the period of impending inflammation. But to be useful the solution must penetrate the injured tissues, and to effect that it is often necessary to make incisions through the skin.

Treatment of Scrofulous Inflammation of Joints.

Prof. HUETER (*American Journal Medical Sciences*), presents the following:

1. Scrofulous inflammation of a joint is characterized by the formation of granulation tissue, so that suppuration follows—while in other forms of joint inflammation, especially the traumatic form, suppuration precedes this formation of granulation tissue.

2. Scrofulous inflammation can be described as leading to the formation of granulations, as a synovitis granulosa, if it proceeds from the synovial membrane; as a myelitis granulosa, if granulation masses are previously formed in the medullary substance of the bones (of the joint). In the latter case the synovitis granulosa follows the myelitis granulosa.

3. In the scrofulous granulations, "noxæ" develop themselves, which, at the seat of the primary disease, lead to the formation of tubercles (local tuberculosis of joints), and by getting into the blood vessels, produces general tuberculosis (lungs and other organs).

4. This form of joint-inflammation may, therefore, be called the scrofulotubercular.

5. That form of joint-inflammation which is produced by congenital syphilis, shows similar appearances; it must, nevertheless, be differentiated, both for diagnostic and prognostic purposes,

since there are no "noxæ" which can lead to tuberculosis.

6. The early stage of scrofulous inflammation may be successfully treated by the injection of 3-5 per cent. solution of carbolic acid. The injection must be made with a Pravaz syringe, in such a way that the solution comes in immediate contact with the granulation tissue, *i. e.*, with the interior of the joint, if the case is one of synovitis granulosa, and with the interior of the bone, if it be one of myelitis granulosa.

7. Antiflogistic treatment of scrofulous joints (fixation, massage, compression, permanent extension, blood-letting, blistering), is of little or no value.

8. Incision into the joints, drainage, scraping away the granulations, or partial venesection of a joint, are to be discarded.

9. Carbolic injections having failed, excision is the best treatment, especially after suppuration has set in.

10 and 11. Excision should be total. When practised early, the results are the most satisfactory.

12. Scrofulous manifestations (local) after excision, are best treated by the application of the actual cautery, and the dusting on of iodoform; or by the introduction of iodoform crayons into the fistulous openings.

Charcot on Sanguineous Deposits in the Fold of the Elbow.

Having had the opportunity of noting five cases of sanguineous effusion in the region of the elbow, and having each time seen the hæmatoma succeeded by a tumour of a cartilaginous consistence, M. Charcot (*Rev. de Chir.*) has embodied the results in an interesting memoir. His conclusions are as follows:

1. Violence which directly affects the elbow, such as contusion, dislocation, etc., or indirectly (as sprains and dias-

tasis), often produce considerable effusion of blood throughout the whole extent of the upper limb, and especially at the fold of the elbow.

2. The sanguineous extravasations seem to have their source in the rupture of the vessels around the joint, and especially in the tearing of the brachialis anticus muscle.

3. The effused blood is not always completely absorbed, and is transformed into fibrinous clots situated at the anterior internal side of the fold of the elbow in front of the articulation, and in the substance of the brachialis anticus.

4. The tumor thus found is as large as an egg, uneven, and of cartilaginous, and even bony, hardness. At the commencement it is independent of the bone; but subsequently may become united to the humerus.

5. The sanguineous deposits may interfere with the movements of the joint, and considerably limit flexion.

6. They generally remain stationary for a long time, and are but little influenced by ordinary treatment.

7. They may give rise to errors in diagnosis, and may be taken for exostoses of the humerus, displacements of the coronoid process, etc.—*London Medical Record*.

Diseases of the Ankle Joint.

At a recent meeting of the Medico-Chirurgical Society, of Edinburg (*Edinburg Medical Journal*), Mr. Joseph Bell showed a patient who had suffered for some years from disease of the ankle joint, but whose foot he had been enabled to save by means of a free antiseptic incision. He thought it was rare that good results were seen in cases of joint disease of long standing. This patient, a boy of nineteen, had suffered from pain in the ankle for nearly five years. For the last two years the pain

had been intense. He was unable to put his weight on it, and sometimes was even unable to sleep at night. The disease was entirely confined to the ankle joint. It was decided to make a free incision and thorough drainage, under antiseptic precautions. The incision was accordingly made. An ounce and a half of pus was let out, and a drainage tube passed into the joint. The symptoms were at once greatly relieved. The patient remained in the hospital about two months, and was sent out with the wound healed and a starch bandage on, to keep the joint quiet. This was now off, and the movements at the ankle were almost perfect and there was no evidence of disease. He will go about for some time on crutches.—*Med. and Surg. Reporter*.

Sucrate of Lime Liniment for Burns.

In the *Concours Medical* we see that in place of the ordinary lime water and oil liniment, M. Constantin Paul recommends one made from sucrate of lime, according to the following formula: Slacked lime and sugar in equal quantities are triturated together. Water enough is then gradually added until the mixture becomes very liquid. It is allowed to stand for forty-eight hours, and then filtered. The solution is evaporated to the consistency of a thin syrup, and this is mixed in equal parts with a solution consisting of one part of glycerine and three parts of oil. This liniment has the advantage of containing a larger proportion of lime in a given quantity. It is applied to burns, and covered over with raw cotton.—*Ibid*.

Sponge Grafting.

Dr. HALE, England (*Brit. Med. Jour.*), reports two cases, attended by good success. In the first the side of the finger had been cut off by a plane; in the

second there was loss of a portion of the penis, subsequent to an operation. In each case a fine Turkey sponge was applied to the granulating surface, and was followed by firm adhesion in four days. In three weeks a thin layer of new tissue covered the edges of the sponge. The object of grafting was, in the first case, to restore proper form to the finger, and in the second, to prevent the awkward results of cicatricial contraction in the penis.—*Ohio Medical Journal*.

Skin Grafting.

Dr. BEYER (*Brit. Med. Jour.*), advocates a method of exciting vascularization of the flap before cutting it, by covering the skin either with a mustard plaster, or with warm poultices. He claims marked success from this method.—*Can. Jour. Med. Sciences*.

DISEASES OF THE EYE AND EAR,

The Uses of Hot Water in the Local Treatment of Diseases of the Eye.

Dr. LEARTUS CONNOR (*American Journal of the Medical Sciences*), calls attention to the value of the systematic use of hot water in the local treatment of diseases of the eye. He holds that this agent is capable of inducing persistent contraction of the smaller blood vessels without having any irritating properties.

How shall hot water be employed?

On the answer to this question hangs the probability of obtaining the results alluded to.

1. The water must be as hot as the patient can comfortably bear with his hand. This temperature will vary with different persons and different eye-diseases. It is a curious fact that the eye will habitually bear with comfort water at a temperature that is very uncom-

fortable to the nose, face and hand applying it. To allay their fears as to the use of very hot water, I usually tell my patients at the first that the nose will be scalded before any harm is done to the eye.

2. The water should be placed in a large vessel, before the patient, on a chair or other support of a height that will readily permit the patient to bend the body upon the hips and the head upon the neck to such an extent as to permit the easy douching the eye by water thrown against it with the whole hand. Neither the hand nor the fingers, nor cloths, nor sponges should touch the eye. Nothing should touch it but the mass of water thrown by the hand with force sufficient to come into firm contact with the eye.

3. The amount of water in the vessel should be sufficient to maintain the temperature tolerably uniform during the entire douching. I usually direct two quarts.

4. The length of time that the douching is to be continued varies with the tissues to be affected and the degree of the inflammation or irritation. If it be merely a superficial irritant, a couple of minutes three times a day may suffice. In deeper seated inflammations, or in more chronic ones, it may be necessary to apply it for five minutes every hour or half hour. The guide for directions in this respect lies in the effects produced in the vascularity of the tissues. If this can be sufficiently reduced by using hot water for two minutes every four hours, it is both useless and annoying to use it oftener. But if the use of it five minutes every half hour is required in order to produce the same effect, then the less frequent and less prolonged use of the water is equally unsatisfactory. In short, it needs to be used as "opium to quiet pain" in doses

sufficient to accomplish the purpose for which it is employed.

To one who has not observed the effects of hot water employed in the manner suggested, there will no doubt be a degree of scepticism concerning the results alluded to. But this will disappear as soon as the remedy is intelligently tried according to directions. Of course it must not be expected that this remedy alone will cure all eye troubles. We have distinctly stated that only certain definite changes will be produced by it; all other changes require other remedies. While the remedy is a simple one and readily available almost everywhere, I know of none that requires more good sense and more care in its use than the one under consideration. Unless it be thus employed its use will be unsatisfactory. But under no circumstances have I observed any ill results to follow even the most careless or inefficient use of the remedy. But such use has failed to bring about the sought-for results.

Cases are detailed illustrative of its value in diseases of the eyelids, conjunctiva, cornea and iris. In conclusion he says:

1. Hot water locally applied has the same power over inflammatory processes in and about the eye as in and about the uterus or any other portion of the body.

2. It has been shown by the late Dr. Pitcher, of Detroit, and by others since his time, that hot water has the power to contract blood-vessels so as to stop hemorrhage and to bring about a more normal state of the local circulation.

3. It is clear that hot water materially limits acute and chronic inflammatory processes, stopping or preventing septic poisoning and suppuration by its power to destroy or to hold in check the superabundance of white and red blood corpuscles and other protoplasmic ele-

ments so numerous at every spot of inflammation or other disturbance of local malnutrition.

4. To accomplish these ends hot water is an invaluable adjuvant to our means for treating all sorts of inflammations of the eye or its appendages.

5. It needs to be applied systematically, as frequently and as hot as is needful to attain the end sought in any particular instance. Further, it must be applied in such a manner as shall not do more harm than good. Thus the use of cloths, sponges, or any similar substance that is brought in direct contact with the eye is likely to set up so much irritation as to largely diminish if not absolutely destroy the good effects of the hot water. The best method that we have found for applying hot water to the eye is to throw it by the handful against the eyeball, taking it from a vessel so situated as to render the act easy and comfortable. At no time should anything but hot water come in contact with the eye. The directions given in the body of this paper more specifically, are such as we have found absolutely essential to obtain any good result, or at least, the very best results.

6. The difficulties in carrying out this treatment are the amount of time and care called for by it. The surgeon who prescribes it must carefully watch that it is carried out exactly as ordered if he expects the indicated results. In most cases he will be materially assisted by the sense of relief from pain and discomfort so generally felt by such as faithfully follow directions.

7. As regards catching cold I generally order that the last douching be taken a half hour before leaving the house by all patients not confined to the house.

8. Used in the manner indicated, to accomplish the ends specified, hot water

is an invaluable remedy in the treatment of diseases of the eye. It will accomplish certain indications of treatment more certainly, more safely, more quickly, and more pleasantly than any other single remedy with which we are acquainted.—*Det. Lancet.*

DIGESTIVE TRACT.

The Treatment of Hemorrhoids by the Dilatation of the Anal Sphincters.

DR. WILLIAM BODENHAMER (*Medical Record*): The treatment of hemorrhoids by the dilatation of the sphincters of the anus, whether gradual, instantaneous, or forcible, is founded upon the theory that the involuntary contraction of one or both of these sphincters is an exciting or an efficient cause of the hemorrhoidal disease, or that it, at least, exerts great influence in its production and continuance; consequently that the dilatation of the anal sphincters is a rational method of cure, doubtless upon the principle that by the removal of the cause the effect itself will cease. But the effect of a certain cause sometimes becomes itself a disease, and exists independently of the cause or disease which first produced it; so that the removal of the original cause in such a case will not remove the original effect, which has now itself become an independent entity. With regard to the hemorrhoidal affection, when accompanied by regular organized tumors, if caused by involuntary contraction of the sphincter ani, I hold that the removal of the contraction alone will not remove the tumors, one of the original effects of it. Indeed, if ever hemorrhoids are caused by involuntary contraction of the anal sphincters, dilatation of these muscles can only act efficiently as a therapeutic remedy in the early stage of the disease, before extravasation of the con-

tents of the turgid vessels into the cellular tissue has taken place and before organized tumors have formed. It will be shown hereafter that even the most zealous advocates of forcible dilatation of the anal sphincters do not rely upon this remedy alone as a cure of hemorrhoids, when organized tumors exist, but combine with it cauterization by the galvano-cautery or by some other process. In such a case, if any cure at all is effected, it is the result solely of the cauterization, and not of the dilatation. Why, then, combine the two methods? I would observe, however, that it is the practice of some surgeons, in case of hemorrhoids, to employ forcible dilatation or rupture of the anal sphincters, not as a therapeutic, but merely as a diagnostic measure to enable them the better to explore with greater ease the seat of the affection, and to operate with greater facility.

I have for a number of years employed dilatation of the anus and anal canal by the use of bougies for the treatment of the incipient stage of the hemorrhoidal disease, with good results. If judiciously employed at an early stage, before organized tumors have formed, it may prove the means of destroying the morbid condition of the vessels, and overcoming any undue contraction of the anal sphincters, and thus preventing the further progress of the disease. The influence of the bougie in removing the morbid sensibility, and in relaxing the rigidity of the sphincters, as well as facilitating the return of the blood from the turgid, congested, and varicose vessels, is often surprising; and if torpor of the rectum and obstinate constipation obtain, which are not unusual in such cases, it soon induces a natural action of the bowels, an object so very desirable in such instances.

The proceeding of M. Verneuil.—M. Ver-

neuil was one among the ablest advocates for the treatment of hemorrhoids by the forcible dilatation of the anus ; but, in order to success, he was compelled, in the majority of cases, to combine with it the galvano-caustic method. The proceeding of Verneuil, in certain cases, comprises two distinct processes : first, the anal dilatation ; and second, the interstitial cauterization of the tumors. I am, however, only required to give his first process. On the evening of the day previous to the operation, M. Verneuil requires the patient to take a purgative, and on the next day, just before the operation, an enema is to be administered. After the rectum is completely emptied by these means, the patient should be put under the influence of an anæsthetic, and placed on his left side, in the position required for the operation of fistula in ano, and a bivalve speculum introduced into the rectum fully up to the superior border of the internal sphincter ani ; then the blades, forcibly opened, should be slowly withdrawn from the rectum. Afterward two fingers of each hand may be introduced into the anus, and forcibly stretching the external sphincter, by which its dilatation will also be the more thoroughly effected. The patient is now put to bed, and compresses, dipped in cold water, are to be constantly kept applied to the anus.

According to M. Verneuil, this operation is done in a minute, and does not give place to any serious complications. There is no fear of hemorrhage nor of purulent infection, nor contraction of the rectum. The pain that follows the operation is not severe, and only lasts for a few hours. For two or three days the dilated sphincter does not completely close the anal orifice, and allows the mucous membrane to protrude at the anus in the form of a hernia ; the

sphincter, however, gradually regains its contractile power, and at the end of five or six days, it has again resumed its normal form and activity, and the patient is completely cured.

The Treatment of Hemorrhoids by Crushing.

Mr. FITZROY BENHAM (*Med. Times*), in a contribution to the *Lancet* (April 15), speaks in enthusiastic terms of the new treatment for hemorrhoids by crushing. From an experience extending to one hundred and thirty-one cases treated in this manner by a clamp especially devised by the writer for the purpose, he says that the results were uniformly successful, painless and bloodless : he says, further, that "in not one instance, with the exception of the first two, was it necessary to apply even a fine ligature, so effectual was the crushing process." The clamp is shaped somewhat like a large pair of pincers, and its crushing power is very great. The following details are given of the operation : "The bowels should be well opened by the aid of some purgative,—perhaps the simplest is either Glauber's salts or the compound senna mixture;—and, in addition to this, it is usually advisable to give a common enema just prior to the time fixed for the operation, and to steam the parts in the usual manner. The patient, having been placed under the influence of ether, should be turned on one side, usually the left, with the buttocks well drawn to the edge of the bed, and with the knee remote from the bed, well drawn up towards the abdomen. The pile to be removed is to be drawn down by means of a pronged fork or vulsellum. The clamp is then to be applied to the base of the pile, and at once tightly and firmly closed by the action of the screw at the end of the

handles. The portion of the pile which protrudes inside the lips of the clamp is then to be removed by a pair of scissors curved on the flat, or scalpel. After the clamp has been allowed to remain *in situ* for about a minute, the thumb-screw may be gradually slackened; but at the same time, particular care must be taken to press the jaws of the instrument well up against the buttocks, so that the surrounding tissues may not be unduly stretched; otherwise they will return into the bowel with an 'elastic recoil,' and will thus have a tendency to tear asunder the 'fringed remnant' left by the clamp. I cannot too strongly impress this on the attention of the operator; for the success of the operation being rendered bloodless depends in no small measure on his taking this precaution. The process is, of course, to be repeated according to the number of masses to be got rid of. If several piles are to be removed, it is advisable to operate first on the lower, or those situated more externally, and then to proceed upward; for by adopting this method the 'fringed remnants' left by the clamp from the former masses will not be subjected to so much tension when the latter are operated on. If a pile be of unusually large size, so much so that it is apprehended that a portion may overhang the sides of the jaws, I clamp the mass in two portions; but before releasing the grip of the jaws from the first portion I divide only a part of it which is within the grip of the jaws, and then take particular care to have a firm hold with the vulsellum of the portion not yet operated on. Occasionally it may be advisable to separate the skin before clamping the pile; but, as a rule, I have not found this at all necessary, or even beneficial, for this reason alone,—the area of the wound to be healed is materially increased. After the operation I simply sponge the

parts, and usually administer an anodyne, not so much for the purpose of alleviating pain, but chiefly to quiet the patient, as he naturally becomes restless for a few hours afterwards, until the effects of the ether pass off. It is as well that the bowels should not act for about five or six days after the operation, but should they be relaxed I administer opium; either the tincture or a suppository, which I also do in those exceptional cases in which patients are peculiarly sensitive to even the slightest pain. On the morning of the sixth day I usually give about three drachms of Glauber's salts in warm water, and if this did not readily act, which may cause the patient some discomfort, I then administer an enema. By this means the motions become loose, thus reducing the pain arising from the hardened feces passing along the tender parts, to a minimum. After the bowels have acted, the parts are to be carefully sponged and smeared over with carbolized vaseline (five grains to the ounce), by gently introducing the finger into the bowel. The diet should at first be light and nourishing, but not stimulating, unless otherwise indicated. It is rarely necessary for the patient to remain in bed after six or seven days, if the bowels have acted, but it is not advisable to allow him to resume any active work for at least a fortnight after the operation, and, indeed, even for a few days longer, if he be a laboring man."

Strychnia in Prolapsus Ani.

Dr. LEONARD WEBER, New York (*Am. Med. Weekly*), inserts the needle into the cellular tissue parallel to the rectum, and about three-quarters of an inch from the anus, and injects one-twelfth grain of strychnia for an adult. The operation is repeated every forty-eight hours till complete recovery takes place; from four to eight injections are needed.

VENEREAL DISEASES.

Treatment of Syphilis.

SIGMUND asserts that the internal administration of mercury is fast losing ground. The chief methods to be employed are frictions and injections. We should still bestow attention upon internal medication, since its application is useful in different spheres of life; but he advises small doses, given once or twice a day: Calomel, $\frac{1}{8}$ to $\frac{1}{2}$ gr.; sublimate, $\frac{1}{4}$ to $\frac{1}{32}$ gr.; proto-iodide, $\frac{1}{3}$ to $\frac{5}{8}$ gr.; deutioduret, $\frac{1}{4}$ to $\frac{1}{20}$ gr. Decoctions are valuable aids to treatment, especially in old skin-and-bone and gummatous conditions.

As an external application for children he recommends corrosive sublimate in ablutions and baths. As an external application, he thinks the gray ointment requires no special indorsement. It is well known. Hypodermic injections are made chiefly with sublimate and calomel.

In children, pregnant women, or very sensitive patients, injections are contraindicated, as well as in those suffering from convulsions, especially epilepsy. In the early stages in the light of evidences of later stages, in pareses or paralyses, injections should be used before we think of frictions.

Calomel is more seldom used than the sublimate, because injections of the first more often produce abscesses. Sigmund has used small quantities daily ($2\frac{1}{2}$ to $3\frac{1}{2}$ grs.), and has rarely seen abscesses and the results have been equal to if not much better than with sublimate.—*Weiner Med. Wochens.*—*St. Louis Clinical Record.*

Clinical Lessons on Syphilis.

THE *Concours Médical* accompanies a notice of the second edition of Four-

nier's valuable work with remarks from which we quote:

"Syphilis in all its forms is here treated in a masterly way, and nothing can surpass the boldness and clearness with which the subject is handled. After reading this work, it would seem as if errors of diagnosis were quite impossible. All the accidents attending syphilis, all the consequences, directly or remotely traceable to it, are dwelt upon, and the importance of careful scrutiny into the previous history of the patients is demonstrated.

Sixty pages of this work are devoted, by Prof. Fournier, to the treatment of syphilis. He recommends the use of mercury, notwithstanding all that has been said, of late, regarding the uselessness and dangers of this therapeutic agent. He reviews the different ways of administering mercury, and finally reaches what he terms *his method of successive treatment*. This consists in dividing the treatment into active periods, during which mercury is administered, and into periods of rest, or disintercourse. According to him there is nothing excessive in leaving patients under mercurial influence for as long even as two years, including the periods of discontinuance or rest. The general condition of each syphilitic patient will indicate what auxiliary medication is required, as mercury alone should not be administered. This is but a very brief sketch of this new edition, which contains many valuable additions not to be found in the first."—*Med. and Surg. Reporter.*

Aborting Syphilis.

Some time ago Gantier found that if an intra-venous inoculation of rabietic virus was made upon sheep, this prevented a second hypodermic vaccination from having effect. Hubert (Lyon

Médicale), claims that something of this kind occurs where another secures immunity from syphilis by carrying a syphilitic child, the virus effecting the mother through the blood. He believes that if intra-venous inoculation were done with the secretion and blood of the initial chancre, that systemic infection might be aborted.—*Chic. Med. Review.*

Rheumatism and Syphilis.

DR. C. B. LOCKWOOD (*British Medical Journal*) has noticed that the prior existence of rheumatism exerts a marked influence on the initial lesion of syphilis, causing it to take on a phagadænic and necrotic character. He believes that this explains the occurrence of many cases of malignant chancre which are from time to time reported by syphilographers. He is inclined to think that in these cases mercury does harm, and that potassium iodide is of very great benefit. His cases certainly appear to indicate that the relationship between the rheumatism and the malignant chancre is more than coincidental, but require further confirmation.—*Chicago Med. Review.*

The Diagnosis of Hereditary Syphilis.

• Professor PARROT is now one of the leading French authorities on syphilis, and hence his opinions are authoritative. He observes that the diagnosis of infantile syphilis is often difficult, both on account of the multiplicity of forms which it may assume, and often because it is often necessary to make a retrospective diagnosis (*Ann. de Derm. et de Syphil.*). Age is of great importance, as certain lesions only show themselves at certain periods of life. It is especially, however, the seat of the affections that has to be taken into con-

sideration. The lesions generally appear on the thighs, the buttocks, the lower lip, and about the chin and angles of the eyelids. One sign, to which much importance has been attached, but which, according to M. Parrot, is often wanting, is the bistre tint of the skin, the cachectic look, and the senile aspect of the face. These are sometimes seen in syphilitic infants, but are most frequently due to malnutrition. All the eruptions due to inherited syphilis have more or less of a violet tint. An eruption due to malnutrition is of a more delicate rose color. The syphilides may be bullous, macular, papular, or vesico-pustular. Pemphigus is the earliest, for it sometimes appears at the sixth or seventh month of intra-uterine life. It is mostly observed at birth, when it is seated on the palms and soles. The contents of the bullæ are turbid or purulent. In children two months old, pemphigus may appear on the trunk and around the axillæ. Such an eruption is not syphilitic. The larger dimensions of the bullæ, the transparency of their contents, and the rapid desiccation, are sufficient to distinguish it from the syphilitic form. Macular and papular syphilides are similar to the corresponding affections in adults. The vesico-pustular eruption is the rarest and latest. The diagnosis is difficult. It begins as a papule surmounted by a vesicle, which quickly bursts, or as a red patch on which a bulla develops and rapidly ulcerates. The affection attacks the abdomen by preference. All these syphilides have a tendency to ulcerate, in which case the ulceration may remain limited to the syphilitic lesion, but sometimes it extends more widely. When the ulcers progress very rapidly, and when they extend to the neck, tuberculosis is to be feared.—*Med. and Surg. Reporter.*

For Gonorrhœa.

After preparing the system as may be required, give the following internally for the first stage:

℞. Ext. buchu fluidi; spts. etheri nitrosi, āā ʒ ij. M. Sig.—A teaspoonful three times a day.

As an injection:

℞. Ext. hydrastis canadensis, fl., ʒ j.; aquæ ros., ʒ jv. M. Sig.—Inject twice a day.

For the second stage of inflammation: Continue the first prescription internally and inject the following:

℞. Quiniæ sulphatis, gr. ij.; acidi sulph. dil., gtt. viij.; aquæ ros., ʒ j. M. Sig.—Half of this mixture to be used at an injection.

In the third stage give internally:

℞. Tr. cantharidis, ʒ j.; quiniæ sulph., ʒ ss.; tr. ferri chloridi, ʒ ij.; acidi sulph. dil., gtt. xxx.; aq. dest. ʒ viij. M. Sig.—A tablespoonful three times a day. Employ mild astringent injections.—*Ther. Gaz.*

DISEASES OF THE SKIN.

Winter Eczema.

There appears to be something in winter climate to cause in many persons a troublesome itching of the skin. This itching abates or disappears during mild or moist weather, but recurs with cold, dry clearing up weather. Light at first, it is apt to become very troublesome, especially upon undressing, and through the night. At this stage vigorous scratching becomes irresistible, and then the surfaces are abraded, red and papular with an exudation which becomes copious, drying in crusts on some parts, but presenting open ulcerative patches on others. In this stage,

itching is replaced by soreness, and the tendency becomes worse instead of better. From a consideration of the climatic conditions which start and keep up this affection in persons otherwise in good health, there was an indication for some agency which would keep the skin in dry, cold weather, as in mild moist weather. This would be accomplished by a proper use of glycerine. An effective astringent like tannic acid is also indicated to correct the tendency to exudation; a moderate stimulation of the surface may take the place of the scratching, and for such indications, such a solution as this will serve: Tannic acid forty grains glycerine and alcohol, each half a fluid ounce; water sufficient to make four fluid ounces.

This solution applied by means of a small sponge morning and evening, will in a large proportion of cases abort the affection. The itching will be reduced or cease altogether, and as the other stages arise from the scratching they will fail to occur. If the affection has gone on to the stage of irritation and exudation before the solution is used, the solution may be found too strong. If diluted with an equal volume of water for a time, until the irritation is less, it will better serve the purpose, but after this the full strength should be resumed. When once the affection is curable in this way, it should never be allowed to go beyond the itching stage before the remedy is applied. The disease is apt to recur at the beginning of the next winter. The solution does not keep indefinitely and should be freshly made for each attack.—*Chic. Med. Review.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Fractures of the Lower End of the Radius Treated so as to Preserve Perfect Use of the Hands and Fingers.

At a clinical meeting of the Philadelphia Co. Medical Society (*Med. Times*), Dr. JOHN B. ROBERTS presented three cases of fracture of the lower end of the radius, in which perfect use of the hands and fingers had been preserved by proper treatment. He called attention to the surgical anatomy of the injury, and especially to the fact that Barton's fracture—that is, fracture of the posterior edge of the base of the radius—probably never occurs. The ordinary fracture is a transverse break in the bone, one-third or one-half inch above the joint. This may be complicated by lines of comminution extending through the lower fragments into the joint. These points have been especially insisted on by Dr. Levis. The treatment adopted was erroneous, not only from the general misunderstanding as to the nature of the injury, but because the splint used was incapable of fulfilling even the theoretical indications. Bond's splint is still much used, but is certainly unsuited, because the lower surface of the radius is curved, and not straight, as is the splint. The practice of throwing the hand to the ulnar side is also useless in the attempt to prevent deformity, as the manœuvre merely rolls the carpus in its socket, and has no action on the displaced lower fragment. The proper treatment is first to reduce the fracture, which can generally be easily done by flexion of the wrist and

pressure upon the lower fragment, and then to retain it by some splint like Dr. Levis' moulded metal splint. Generally the fragment, if comminution does not exist, will remain in place without much difficulty when once adjusted. In Dr. Roberts' opinion, better results would often be attained if the subsequent treatment consisted in merely carrying the arm in a sling, than from the use of the Bond's splint in the ordinary way, without a pad to correspond with the curved radius. It is no uncommon thing to see these fractures treated in such a manner that, after the cure, the ulnar eminence is on a level with the palmar surface, because the flat Bond's splint has been applied to the arm and hand. As the lower fragment is by the force of the injury thrown upward and backward on the dorsal surface of the upper fragment, impaction may take place, and then more difficulty is experienced in reduction; but such reduction is absolutely necessary to prevent deformity and stiffness of fingers from the extensor tendons becoming involved in the callus.

The general details of the fractures and the modes of treatment were explained by blackboard diagrams, after which the three patients were presented for examination.

Dr. Roberts said that two of the patients had each sustained a fracture of one wrist, but that the cure was so good, regarding both anatomical accuracy of adjustment and perfect mobility of joints, that he doubted whether the injured wrist could be detected by all the members of the Society present. He therefore would not mention which arm

was injured, but leave each examiner to make his own diagnosis. The third patient was an imbecile old woman who had fallen from a second-story window to a roof, and thence into the yard of her residence. Both radii were broken, and it was believed that comminution had occurred. Reduction was effected by flexion and pressure, and the same splints used as in the other cases—namely, Levis' moulded metal splints. The mental condition of the patient interfered with treatment, for she continually pulled off the bandages and splints; and yet perfect mobility of all the joints was obtained, though considerable deformity from prominence of the ulnus existed. In these three cases, two of which were of quite recent occurrence and the temporary callus therefore probably not yet entirely absorbed, the splint had been worn for three or four weeks; but during the entire time of treatment free motion of the fingers was allowed, and was possible because primary reduction of the lower fragment gave no opportunity for callus and displaced bone to interfere with the tendons.

Dr. Packard thought the cases presented by Dr. Roberts of great interest, and the results obtained in them extremely good. Among the specimens there was one which is almost unique, being a detachment of the styloid process by itself. Another showed extremely well one way in which comminution of the lower fragment is sometimes induced, the upper fragment in a Colles' fracture being driven into the lower so as to *burst* it into two or more pieces. In this way are produced the "starred" fractures, of which two very good specimens exist in the Warren Museum in Boston.

He believed that impaction was the rule in cases of transverse fracture of the radius near its lower end, and sev-

eral of the specimens shown illustrated it. This view, which was held by Callender (St. Bartholomew's Hospital Reports, 1865), is of much importance in the matter of treatment, since it explains in part the extreme difficulty of reduction sometimes met with, the other principal cause of this difficulty being the tension of the ligamentous structures insisted upon by Pilcher.

Upon careful examination of the normal forearm and hand, it will be found that in front, just above the wrist, there is a prominence marking the lower extremity of the radius, the anterior face of which bone presents a decided concavity. Below this, again, there is the much larger swell of the ball of the thumb. For both these, allowance must be made in fitting a splint in cases of Colles' fracture. A perfect splint would represent an exact mould of the normal parts; but this, of course, cannot be made. Levis' tin splint, shown by Dr. Roberts, answers a very good purpose.

In the treatment of these cases the first essential is the perfect reduction of the fracture, as to the ease of which he thought Dr. Roberts had spoken somewhat too confidently. Sometimes it is indeed very easy, but oftener it is difficult, and cases occur in which it is impossible. The way to accomplish it is not by extension nor adduction, but by careful, gentle, and patient manipulation, with anæsthesia if necessary. The obstacles have been mentioned above.

After reduction, the retention is seldom difficult, but, in his opinion, it would never be safe to let the forearm and hand simply lie in a sling, as the leverage would be too great. He had, however, used a mere block, carved to suit the normal anterior face of the bone, and held in place by adhesive plaster, with the best results. The

block was covered first with canton flannel.

Bond's splint, as commonly used, Dr. Packard thought a most inefficient appliance and a fruitful source of deformity. He had seen it employed in an unreduced fracture, the splint being altogether too large, and a pad carefully placed to maintain the interosseous space, which had never been interfered with at all. By effecting reduction and placing the hand and forearm on a well-shaped splint (in this instance that of Coover, of Harrisburg), a really perfect cure was accomplished. He thought it of the utmost importance first to insure reduction, and then to maintain it by any apparatus that would secure that object.

The Treatment of Transverse Fracture of the Patella, with the Object of Producing Bony Union.

Dr. R. J. SERIS, of Philadelphia, in his paper on the subject read before the American Surgical Association, first called attention to the fact that the patella not being a symmetrical bone, it was hard to make any well fitting appliance to it. Then again, as it has no natural depressions to which to apply force, the application of such force creates unnatural depressions, tends to cast the fragment upwards, and even if it could bring the lower edges of the fracture together, it would separate the upper edges. The result of ligamentous union is apt to be lameness, inability to use, and mistrust of the injured leg. Bony union is very rare. It has been doubted if it ever occurs. With the ordinary apparatus he did not believe it could ever be secured. But he and Dr. Morton had for some years been using a modification of Malgaigne's hooks with which he believed he had secured it. His own modification con-

sisted in separating the hooks of one side from those of the other, so that they can be inserted first on one side of the fragments and then on the other. He then showed two patients who had been treated in this way, in whom no motion could be made between the former fragments, and who had complete confidence in the use of their legs.—*St. Louis Cour. of Medicine.*

Treatment of Fractures of the Skull, Recent and Chronic, with Depression.

Dr. MOSES GUNN, of Chicago, read a paper on this subject before the American Surgical Association.

He called attention to the general sentiment of the profession since the days of Abernathy and Cooper, against interference in cases of fracture unless symptoms of brain irritation or of compression are urgent. In this American and English surgeons were agreed. Gross seemed to go to the farthest in the direction of interference where there is a depression, not postponing it as long as most authors advise. The question now arises: Are we not too conservative in our treatment of fractures of the skull, with depression, whether simple or compound, even though entirely without symptoms of compression, if there is reason to believe that the internal table is depressed and if there are no symptoms of marked concussion or collapse, elevation of the depression should be promptly effected. In fractures from external force, injury is apt to be more severe to the inner plate of the skull than to the outer; and even when this does not occur and constitute an immediate danger, there is the possibility of the formation of osteophytes and spicula of bone, which at a later period will be a source of danger to the patient. The

danger of interference having been reduced nearly to zero by antiseptic methods, we are warranted in operating where formerly we would not have been.

He then spoke a word for the much abused trephine. Statistics of bad results after trephining, in order to show that this was the cause of them, should be able to show that there was no irritation or inflammation before it is used. If the dura mater has not been injured already, it will not be by the trephine; no careful surgeon would do this. In chronic cases, *as soon as positive*, even though comparatively *slight*, symptoms of cerebral irritation present themselves, a disk of the cranial walls, intending to include the cranial point, should be removed with a trephine of requisite size, which should include the whole depression, or at least the most depressed portion of it. Subsequent irritation is often due to the formation of osteophytes, and he believed that the cases successfully treated would be found to be those in which early interference has been made. All operations and dressings should be conducted upon strict antiseptic principles. —*Ibid.*

Congenital Dislocation of Patellæ.

Dr. T. F. PREWITT, (*St. Louis Courier of Medicine*): David Q—; aged 38 years; occupation, painter; weight about 145 lbs.; light hair; fair complexion, and average development; came to Surgical Clinic Dec. 16, 1881.

I examined patient and found, where the knee caps or patellæ should have been, cavities with boundaries, for the reception of fully formed and developed patellæ.

Both internal and external condyles seemed to be abnormally large.

Knees when flexed presented a flat surface slightly concave from side to side.

Both patellæ were found on the ex-

ternal surface of the thighs just above and to the outer side of external condyles. Measurement, transversely and longitudinally, gave $1\frac{1}{2}$ and $1\frac{3}{8}$ inches respectively. Both plates were much thinner than normal. Right patella very slightly larger than left, as is also the case with the cavity and bones that enter into the formation of right knee. Ligamentum patellæ observed beneath skin, to be narrow and elongated, when put on the stretch by abducting and rotating leg outwards.

No other deformity exists, except a "webbed" condition of little and fourth toes, on both feet.

The function of patellæ is almost the same as when located in normal position, but the new position as indicated passes somewhat behind the center of motion of the knee, when the joint is bent, and causes the quadriceps to act as a flexor of the leg upon the thigh.

Both quadriceps extensors are fairly developed. When the patient stood erect, the knees were inclined inwards, the feet outwards, and his gait was unsteady when he walked.

He said that his health, as a rule, had been good, and his physique was such that he had been employed as a deck hand, in which capacity he was obliged to carry heavy weights.

History.—Says that he was born in the condition mentioned, and is not aware of ever having suffered an injury of the knees. His grandfather on father's side, father, one brother and sister, and one of his own children, had displacements of both patellæ above external condyles.

Remarks.—This case is of peculiar interest, because the same displacements extend through four generations, showing conclusively the important part that inheritance plays in growth and development.

The only recorded case which approaches this in interest has been reported by Dr. Caswell, in which five members of the same family had double congenital dislocations of the patellæ.

The Treatment of Gunshot Wounds of the Abdomen in Relation to Modern Peritoneal Surgery.

Dr. J. MARION SIMS delivered an address on this subject, which has been published in the *British Medical Journal*, from which we note the following salient points:

The principles essential to success which must guide us in all operative treatment of abdominal wounds are—

1. All hemorrhages must be promptly controlled by pressure, ligature or hæmostatic forceps.
2. The peritoneal cavity must be thoroughly cleaned after operation and before the abdominal incision is closed.
3. The abdominal incision, usually in the middle line, must be properly closed. The divided edges of the peritoneum should be included in the sutures that close the abdominal wound, for if they are not, their raw edges may become adherent to the intestine in such a manner as to cause obstruction to the bowel, when a fatal result may follow. Commenting on the drainage tube, he advocates its use, but cautions us against the danger of ventral hernia from its employment, and recognizes the necessity of discovering some method of avoiding this serious accident.—*Med. and Surg. Reporter*.

New Method of Treating Wounds and the Use of Corrosive Sublimate in Surgery.

The attempts to get all the advantages of a perfectly antiseptic dressing, with the simplest methods, had led to many experiments. The iodoform dressing

had become very popular, but, in Kümmell's opinion, its era is past.

An excellent dressing was a mixture of heated charcoal with clay, in the proportion of 1 to 7. It possessed not only great disinfecting but powerful absorbing properties. The first dressing can be left on for one or two weeks, and there is no inflammatory reaction or disturbance. The substance is especially good in large cavities, as after operations near the rectum. The powder sticks so closely to the surface that it is not easily washed away. In eight or ten days it may be removed and the wound dressed with basilicon ointment.

The above dressing, however, the author found to be dirty and to have some disadvantages. He therefore experimented with corrosive sublimate. It is known that solutions of this, of the strength of 1 to 1,000, destroy bacteria. Kümmell used solutions of the strength of 1 to 2,000, washing the wound with it. Instruments, catgut and dressings are disinfected completely by soaking twelve hours in a one per cent. solution. Kümmell also used as a wound-dressing fine quartz sand, heated, and then disinfected with a solution of sublimate. This seemed especially advantageous for primary healing. He also used fine spun glass, or glass-wool, and considered it useful on account of its draining property. The fine threads of glass lying together acted as capillary tubes. The wound-surface could also be examined to some extent through the transparent dressing. There is no irritation from this substance, and primary intention occurs very certainly. Herniotomies under this treatment have got well in five to eight days, necrotomies in fourteen days. Either the sand or the glass-wool method is very simple.—*Med. Record*.

Twenty Needles Swallowed and Passed per Rectum.

A boy of three years, while playing with a needle-case, swallowed twenty needles (5 c. m. long). Five days later sixteen needles were passed *per anum*, glued together by feces. The remaining four came out, one by one, on the sixth and seventh days. There were no symptoms except occasional abdominal pain, and no treatment.—*London Med. Record*.

Radical Cure of Varicocele.

The intravenous injections of chloral hydrate is the latest suggestion for the treatment of varicocele. Dr. ANGELO NEGRETTO (*London Medical Record*) reports two cases in which he obtained a speedy and permanent cure by intravenous injections of chloral hydrate. He uses a solution of chloral hydrate, seven grains to the ounce, and injects in several points in the mass. Mild orchitis followed in both cases, but within a week all signs of the operation and the varicocele had disappeared.—*South. Med. Record*.

Cure of Goitre by Fluoric Acid.

Dr. EDWARD WOAKES gives, in the *Lancet*, a detailed account of a number of cases of goitre cured by fluoric acid internally. He begins treatment with fifteen minims of a one-half per cent. dilution of the acid three times a day, and, if necessary, increases the dose to twenty, thirty, forty or even seventy minims, and extends the time to several months. His results are quite remarkable, even in cases that had resisted iodine, bromine, iron, etc. In a few it was conjoined with injections of tincture of iodine. Very few failed to be reasonably benefitted, and in eighty-five per cent. the cure was decided.—*Louis. Med. News*.

Hydrocele of the Neck.

At a recent meeting of the Glasgow Medico-Chirurgical Society (*Glasgow Medical Journal*), Dr. JAMES WHITSON reported a case of hydrocele of the neck. He first spoke of their extreme variety. The patient was a girl, 7 years of age, and the hydrocele was situated on the right side of the neck. It had first appeared when she was 5 months old, since which it had gone on increasing in size, but had never caused any inconvenience. The head was carried slightly to the left side. There was an oblique depression in the tumor corresponding to the sterno-mastoid. On August 14th, 1881, it was evacuated by the aspirator and continuous pressure afterwards applied. By the middle of November the cyst was as large as ever, and on the 18th, with antiseptic precautions, an incision was made into it. When it was thoroughly evacuated, tincture of iodine was applied to its interior by means of a brush. Decalcified drains were then introduced, and the wound dressed. Five weeks after operation the wound was healed, and the hydrocele has been completely cured. In discussion, it was considered that this mode of treatment was an improvement on the old method. Stuffing the sac with lint had been tried, but it set up a great deal of inflammation and caused puckering of the skin. Setons had also been used. One case was mentioned where the cyst had been washed out with chloride of zinc, and the result was good.—*Med. & Surg. Reporter*.

Laparotomy for Intestinal Obstruction.

A young girl, 16 years of age, suffering with constipation, vomiting, and abdominal pain, after being dosed with purgatives by her mistress for three days, without result beyond increase of the

symptoms, was seen by Dr. JOS. BELL (Edinburgh *Medical Journal* for July), who found these symptoms, but no special tenderness in flanks or abdomen; pulse and temperature both normal. Nothing was made out by abdominal manipulation except a small deep-seated point of extra resistance, about one and a half inches to the right of the mesial line of the abdomen, just below the level of the umbilicus. The diagnosis of intestinal obstruction was made, and opium treatment instituted, with ice and large enemata. Four days later, laparotomy was performed with antiseptic precautions, and an intussusception, a volvulus, and an incarceration of a loop of intestine by a tight band were successively found and released. The patient survived the operation only twelve hours. The case is interesting from the fact that the diagnosis was made during life, and laparotomy performed earlier might have averted the fatal result. — *Med. Times*.

Dry Treatment of Caries.

Dr. ENGLEMAN (St. Louis *Courier of Medicine*) describes a number of cases of caries treated simply with cotton, in the children's hospital in Paris some ten years ago. The method of treatment resorted to for years, and for which they claimed absolutely perfect results, was to bandage the entire limb very thickly in cotton, which being once put on was not removed for six months, perhaps, and when it was removed the once foul suppurating wound had completely healed. — *Med. Record*.

DISEASES OF THE EYE AND EAR.

Boracic Acid for Granular Lids.

Dr. JAMES L. MINOR says (*Va. Med. Monthly*) that he has found boracic acid powder a most excellent application to

granular lids. It is used as follows: The lids being thoroughly everted, the powder is spread freely over the whole conjunctival surface with a camel's hair brush. The acid is generously applied, and mixing with the discharge from the lids, it readily gains access to the cracks and crevices between the granulations, and thus comes into direct contact with the entire surface upon which it is intended to act. The immediate effect is to increase lachrymation and to cause a burning, gritty sensation, with some pain. These symptoms usually pass off within ten minutes, and are followed by an amelioration of all the symptoms which existed before the application of the acid. The granulations may look less gorged and prominent, but he has not been able to discover much change in the naked eye appearance of the conjunctiva after one application. The powder was used three times a week. The improvement is so gradual that it is almost imperceptible as it progresses, but Dr. Minor has derived more satisfactory results from the use of this powder than from the ordinary caustic or astringent applications.

Application of the Cold Douche in Blenorrhœa Neonatorum Complicata.

Dr. O. PAULSEN, of Hamburg, describes (*Berlin Klinisch. Wochenschrift*) the troubles attending the treatment of severe cases of ophthalmia in infants. The very rapid secretion of pus and the spasmodic closing of the lids are the factors which especially make it difficult to treat these cases satisfactorily. Dr. Paulsen thinks that the cold douche remedies these difficulties, however. In severe cases this must be repeated every ten or fifteen minutes, then every half hour or hour, each application lasting two or three minutes. It is surprising, says Dr. Paulsen, to see how quickly the

tension of the lids relaxes and the conjunctivæ becomes visible.—*Med. Record.*

Pilocarpine in Detachment of the Retina.

Dr. EUGENE SMITH, in his report of the Eye and Ear Department of St. Mary's Hospital, Detroit, says :

"During the past year I have had opportunity to test the use of pilocarpine or jaborandi in five cases of *detachment of the retina*. Success has followed its use in three cases, and slight improvement in two, and we have at last found a remedy for many cases of what was till recently considered an incurable condition."—*Ibid.*

Hordeolum.

One of the most frequent and unpleasant of the diseases of the eyelids (especially unpleasant if it occurs in one's own person), is a sty. Stellwag says ("Treatise on the Diseases of the Eye," by Dr. Carl Stellwag), "sty is a swelling of a tarsal gland, which is filled with a substance resembling pus, and occurring with inflammatory symptoms." Wells says ("Treatise on the Diseases of the Eye," by J. Soelberg Wells), "this disease is not, as is sometimes supposed, an inflammatory affection of the meibomian glands, but is a furuncular inflammation of the connective tissue of the lids, having its seat, generally, in the vicinity of the hair follicles and near the margin of the lid." Which of these two authorities is correct, is not for me to decide, but for myself, I prefer to regard a sty, as Wells describes it, as a furuncular inflammation of the connective tissue of the lids.

Every one is familiar with the appearance of a sty. Beginning as an apparently harmless pimple, it soon develops a more or less angry inflammation, and passes through the ordinary stages of

suppuration and discharge. In some cases there may be a good deal of feverishness and constitutional disturbances; but even if there is not, the patient feels disinclined to perform his ordinary duties, and can only use his eyes with considerable discomfort. The swelling, too, causes a good deal of disfigurement, and sometimes is sufficient to close the eye.

In the *treatment* of this troublesome affection, it is well to remember that a sty can seldom be "backed," that is, the disease seldom undergoes resolution; and the trial of various measures for the prevention of suppuration by the application of cold compresses, etc., is simply a loss of time and prolongation of the trouble. And, therefore, I consider the early application of hot poultices as *the* treatment. These poultices should be changed frequently, as often as every fifteen or twenty minutes, and thus the sty is hurried through its various stages, and often brought to a head in the course of ten or twelve hours. I usually order the ground flaxseed to be mixed with a dilute solution of sugar of lead, or have a few drops of the lead solution sprinkled over the poultice at each renewal, as the lead serves to allay the scattering inflammation and to concentrate it.

It is a mistake to pick at the sty with needles, to see if matter has formed; this, almost invariably, aggravates the trouble. The physician should wait until he is sure of the existence of pus, that is until the skin has become thinned and the apex of the swelling presents an unmistakably grayish-yellow tint; then a small incision should be made, to permit of the ready escape of the pus, and pressure should be made along the edge of the lid, toward the opening, so that the contents of the swelling may be thoroughly evacuated, and then in many

cases the styé is practically well. After the incision, the inflammation always rapidly diminishes, the pain, which may have been quite severe, abates, and any further trouble from the hordeolum is scarcely to be feared, or perhaps the swelling may have opened spontaneously, in which case there remains nothing for the surgeon to do but to make the opening more complete and to fully evacuate the contents of the swelling by pressure.

Very frequently, however, a styé on the lower lid is followed by one on the upper lid, and the disease shows a great tendency to recur again and again, so that it would seem as though some individuals and some constitutions were especially liable to it. It is said to occur most frequently in persons of delicate health, and doubtless is an indication that one's system is below par.

It is in these cases that most authorities advise the use of tonics; but of all the remedies that have been recommended in this condition I think that lime is decidedly the best. It seems to have a specific influence over those cases of inflammation of cellular tissue which terminate in suppuration. Given a case in which boils are being continually developed, the use of lime will effect a radical cure. It may be given in the form of lime water, in doses of a wine-glassful three or four times a day; or in the form of calcium sulphide, which is perhaps the preferable form, in doses from of $\frac{1}{10}$ to $\frac{1}{4}$ grain three or four times a day. In prescribing the sulphide I order the pills or granules in preference to powders or a solution of the remedy, as I find in the latter forms it deteriorates rapidly.

Variolous Eye Disease.

Dr. M. D. MAKUNA (*British Medical Journal*) says eye complications in va-

riola occur on the lids, conjunctivæ and cornea. The pustules on the eyelids may be found between the eyelashes where they occasionally cause madarosis (loss of the eyelashes), on the margin of the palpebral conjunctiva, where they may obliterate the Meibomian gland ducts or cause entropion, or produce closure of the eyelids resulting in temporary loss of sight. The eyes should be bathed in warm water frequently, and the lids prevented from sticking together with a drop or two of castor oil. When the vesicles mature, they should be opened with a fine, flat needle. Conjunctivitis variolosa occurs in eight per cent. of the cases usually during the first six days of the eruption. Chemosis occurs in one per cent. of the cases, more frequently in hæmorrhagic variola. Puerulent ophthalmia is not frequent in variolous cases. Zinc sulphate lotion (three grains to the ounce) answers well in mild cases. In slightly severe cases, silver nitrate lotion (one grain to the ounce) answers well. Where the phlyctenular vascularity is small, deep and circumscribed, dusting in calomel yields good results. When associated with lid redness and thickening, ung. hydrarg. subflava is of value. Severe mucopurulent cases usually yield to silver nitrate solution (ten to twenty grains to the ounce). In chronic inflammation, copper sulphate lotion (three to five grains to the ounce) is very useful. In obstinate cases blisters behind the ears answer very well. Potassium iodide solution (three grains to the ounce) answers where blood has been effused to produce absorption. Variolous corneitis is an inflammatory affection, and occurs in one and seven-tenths per cent. of the cases. It begins at the surface of the cornea, which looks dull, dry and uneven. Sometimes the superficial layer is raised so much as to resemble a vesicle.

This results in a white spot which grows in extent and may be attended with photophobia. It results as a rule in recovery. Partial staphyloma and prolapse of the iris may result. In rare insidious and neglected cases, total staphyloma, acute glaucoma and suppuration may result. The lens occasionally escapes through an opening produced by suppuration. Atropia is of great value. Eye protectors are at times needed to keep the eyes at rest, in children.

Pulsating Exophthalmos.

Dr. NOYES (*Medical and Surgical Reporter*). A girl, four years ago, after some severe form of fever, was suddenly taken with a pain in the left side of the head, and about the left eye; the globe began to protrude, and within one week there was marked exophthalmos without inflammatory disturbance. For four years the condition of the eye remained substantially unchanged, except that she had occasional attacks of fugitive inflammation. While passing through Dublin, on her way to America, she had a severe attack of inflammation of the eye. On her arrival in New York she came under his observation. He found swelling of the lids, considerable ecchymosis. There was marked protrusion of the globe, and at the lower and inner angle of the orbit a projection was felt, which at first seemed to be a solid growth. Pulsation, however, was felt, and an operation was proposed. Examination under either showed the tumor to be a distended blood vessel, which came from the orbit forward, and returned upon a loop. A bruit was heard over the exophthalmos, but not upon the temple. Pressure upon the carotid completely stopped the pulsation, but had no effect upon the protrusion. From this he concluded that it was

a purely vascular anomaly, and not wishing to perform so grave an operation as ligation of the carotid, and not being clear with reference to the diagnosis, he decided to ligate the angular artery, and to dissect down to the enlarged vessel, and tie it off. With great difficulty he succeeded in ligating the angular artery. Then dissecting up the protruding vessel, which was as large as a good sized lachrymal probe, he traced it down, placing one ligature after another in the vessel, and cutting between them. He demonstrated that it was a vein, which he finally ligated at the spheno-maxillary fissure. He then concluded that it was the anterior orbital vein, coming out of the spheno-maxillary fissure, and going back to empty into the cavernous sinus. The wound healed kindly. At the end of six weeks the exophthalmos had disappeared.

VENEREAL DISEASES.

Employment of Permanganate of Potash in Blenorrhagia.

We have already noticed the good results obtained by M. M. Spillman and Weiss in the treatment of blenorrhagia by permanganate of potash. These authors base their treatment on the rapidly destructive action of this substance on the microbe which they discover in blenorrhagia. The same means was made the subject of a work by M. Gorgues, analyzed in the *Journal de Méd. de Paris*. It was at the prison of Saint Lazare that these essays were written.

Most of the cases of blenorrhagia and vaginitis brought to notice have passed the acute stage; chronic discharges running on for months absolutely rebellious to any other mode of treatment, have completely disappeared in twelve or fifteen days. For whoever has been able to

follow cases of blenorhagia in females these results have been truly marvelous. M. Gorgues employed solutions of $\frac{1}{100}$ or $\frac{1}{500}$. The tolerance of it with the female is remarkable. The pain is nothing, or almost nothing. There is never seen, even with the injection of a solution of $\frac{1}{100}$, a discharge tinged with blood, such as takes place just after the employment of caustics. No particular means of using it is to be observed. If the injection penetrates into the bladder, there is no cause for uneasiness. On the contrary, Demarquay has treated with success cases of chronic cystitis in this way. M. Gorgues gives one sometimes two injections per diem. With man the injection of $\frac{1}{100}$ has determined a slight dryness.—C. E. C.—*Cincinnati Lancet and Clinic*.

Double Hydrocele, Gonorrhœa.

Clinics of D. HAYES AGNEW (*Med. and Surg. Reporter*):

This young man has had these swellings in the scrotum for two years; that on the left side being the larger. They have been examined by transmitted light and found to be translucent. We have, therefore, a case of double hydrocele. He also has a clap; has had it for about a week. He does not want the liquid removed, and you will find, as a rule, when the accumulation is not more than this, and when the tumor is not of sufficient magnitude to cause inconvenience that the man may go for five or six months longer without the operation becoming necessary.

The operation is simply puncturing the sac and allowing the fluid to escape, or, if the radical operation is desired, injecting into the sac, after the removal of the liquid, a little stimulating fluid, as the tincture of iodine.

What is of more importance to him is,

I think, the cure of this urethritis. It is a specific urethritis, and balanitis, for it extends not only over the head of the penis, but also over the prepuce. The discharge began only three days ago. It is therefore young. The best treatment would be an injection of sulphate of zinc gr. j. to water f. $\frac{3}{4}$ j. thrown into the urethra three times a day, holding the orifice of the urethra around the nozzle of the syringe, retaining the injection inside of the canal for five minutes, at the same time rubbing the under surface of the penis with the hand, so as to distribute the injection over every inequality of the membrane. This is strong enough for the first two or three days. After four or five days the strength may be increased to three grains to the f. $\frac{3}{4}$, and if necessary you can go up to five grains, but it is usually not necessary to go beyond three grains. This will cause the discharge to disappear in the course of ten days. There are certain drugs, as copaiba and cubeb, which may be given internally and will facilitate the cure. Ten minims of the balsam of cubeb or copaiba, in capsules, may be given four or five times a day. I am in the habit of making the injections of the maximum strength at once, and then let the patient reduce the strength by water, as required. This makes the expense to the patient much less.

Lime Water in Gonorrhœa.

KUCHENMEISTER recommends as an abortive in gonorrhœa, injections of lime water, used half hourly and hourly. The acute symptoms of the malady will thus be diminished, and safely permit the use of astringent remedies. Among these last he prefers alum 1 to 10 to 150 of water, with the addition of 5 grammes (75 grains) of a solution of salicylic acid to 100 parts of water.

Lime water should be kept free from air to prevent transformation into carbonate of lime.—*Ther. Gaz.*

Orchitis.

PROF. WHITEHEAD (*Rocky Mountain Med. Times*), in a clinical lecture said : There is no disease in which you can show the immediate benefits of a judicious management of the case so promptly and effectually as in the proper treatment of orchitis. Gaussail, a French physician, found the mean duration of epididymitis in 73 cases to be from 30 to 35 days ; but under proper treatment the duration of the disease may be abridged to a week. After an imperfectly cured orchitis, there is frequently some pain following the sexual act, and this should warn the patient to seek medical advice. I would like to remind you that sometimes infants or very young children have orchitis ; and that often the cause is quite unknown. But do not forget that there is a syphilitic disease of the testicle, sometimes called benign fungus, that is most common in childhood.

After what I have told you, it is quite impossible to fail to recognize a case of orchitis, except possibly in a case of an inflamed testicle, retained at the abdominal ring, and which might be mistaken for strangulated inguinal hernia.

If the disease is in the acute stage, rest in bed for a few days is absolutely necessary. Let me advise you not to content yourself with simply supporting the testicles with a cloth or pillow placed between the thighs, but adopt the plan recommended by Curling, and apply a large silk handkerchief, if the patient should have one, or if not, a large piece of cloth folded in triangular form, and to which is sewed two narrow strips of muslin, about eighteen inches long at

the center of the base of the triangle, formed by the folded edge of the handkerchief. Tie a narrow piece of cloth, or long handkerchief around the waist, just above the hips ; then pass the folded edge of the handkerchief carefully, under the scrotum, passing also the narrow strips of muslin under the thighs, and carrying them up behind, or rather to one side, tie them to the band or handkerchief fastened around the waist. Now draw up the two pointed corners of the handkerchief, which are in front, and fasten them to the encircling band around the waist. In the early stages of acute gonorrhœal orchitis, the testicle and scrotal parts are often two or three times their natural size, and it is impossible generally, to obtain a suspensory bandage large enough, and that will fit the patient comfortably ; besides the handkerchief, if large, will allow of the use of poultices.

I wish particularly, that you remember that a fair sized silk handkerchief, which is so soft and comfortable to the patient with acute orchitis, is much to be preferred to any other means of suspension of an acutely sensitive and inflamed testicle.

I know of no remedy that will allay the pain, and subdue the inflammation of a swelled testicle so effectually, as a tobacco and flaxseed meal poultice. This application was used by some New York surgeons long before it became much known, and Van Buren and Keyes have probably done more than any others to spread the knowledge of its use. A hot flaxseed meal poultice to which has been added previously, about half a paper of fine cut chewing tobacco, should be applied fresh two or three times a day, until the swelling and pain subside. A piece of oil silk should be placed outside the poultice to prevent

evaporation. This poultice gives relief quickly, and in the course of a few days, the swelling is so reduced that an ordinary suspensory bandage may be worn with comfort. After this, paint the parts twice a day with a mixture containing a quarter to a half an ounce of tincture of belladonna, and an ounce and a half of Squibb's fluid extract of ergot. During the severity of the pain, or for the first few days, you may to advantage in robust subjects, give eight grains of Dover's powder, with two grains of calomel at night, with a view to quiet pain and prevent subsequent induration and thickening of the epididymis, and thus preserve unimpaired the function of the testicle. You will find, even in summer, that cold applications rarely do good, and in my opinion, they cause harm, and retard recovery. To support the testicle well, and narcotize it with tobacco poultices, will yield you excellent results.

You should suspend the use of all stimulating balsamics and give your patient demulcent and alkaline drinks. Sometimes it may be advisable to apply a few leeches to the cord, or to puncture the tunica vaginalis; but this will rarely be required. Strapping the testicle has almost gone out of use, and this is due largely to the inefficient manner in which it is usually done; and unless well done, more harm is apt to result than good. But strapping is a valuable resource sometimes in chronic orchitis; but I think that with a well fitting suspensory bandage you can usually dispense with strapping. A certain attention to constitutional treatment is very important in many cases. An occasional laxative and unstimulating diet are required for the robust; but quinine and tonics are useful for patients in feeble general health. For cases of chronic orchitis, in which you

suspect a syphilitic taint, give the bichloride of mercury in 1-16 of a grain doses, with doses of 20 drops of muriated tincture of iron. And do not neglect a trial with large doses of iodide of potassium; but of this I shall speak to you more hereafter. It was taught, I believe by Velpeau and others at one time, that incisions of the testicle could be made without much fear of harm to this organ, to relieve the pain, and tension caused by orchitis. I advise you to be careful how you incise the testicle, because hernia of the seminiferous structure has been repeatedly the result of such incisions, as reported by French authors, and by Curling and others.

Abortive Treatment of Buboec.

Dr. M. K. TAYLOR, Assistant Surgeon, United States Army, describes (*American Journal of Medical Sciences*) a very successful method of treating buboes, adopted by himself. When the glands have reached a moderately large size, he freezes the surface with ether, seizes the gland between the fingers and injects about twenty minims of a carbolic acid solution (gr. iv. to 5 j.) Pain and soreness leave very soon, and the patients are generally able to resume work within three or four days. Dr. Taylor has tested his method on as many as 150 cases. He has used it successfully also in non-specific enlargement of cervical glands.

Impotency.

I am charmed with the effects of celerina (*Richardson, St. Louis*) in nervous and sexual debility. It is simply the most efficient nerve tonic in the materia medica. I have treated several cases of impotency, that had sorely tried my patience, with complete success under the use of celerina, in teaspoonful doses, four times a day.

I can say from experience, that the following combination will give perfect satisfaction in the treatment of nocturnal emissions: *R.* Celerina, 8 oz.; Bromidia, 1 oz. *M. Sig.*: One teaspoonful three times a day in water or syrup.

This will stop the emissions, strengthen the sexual organs, and build up the nervous system at the same time.

DISEASES OF THE SKIN.

Chrysophanic Acid Internally.

The use of chrysophanic internally in psoriasis is something of a novelty. Dr. NAPIER (*Glasgow Medical Journal*) has recently treated two cases of psoriasis by the internal use of chrysophanic acid. The beginning dose was one-eighth of a grain rubbed up with sugar of milk, and gradually increased. The results obtained were excellent. The remedy is sometimes too irritating externally, in which case its internal use would seem to be indicated. In the resulting discussion before the Glasgow Medical Society, Dr. Charteris was of opinion that the drug acted by absorption, which was also the opinion of Dr. Stevens. Dr. Napier believed that psoriasis was cured by chrysophanic acid, given internally.—*Chic. Med. Review*.

Rufigallic Acid In Psoriasis.

Dr. LANCY, Inspinck, Germany (*Edinburgh Med. Journal*), claims that this acid used in a salve of one part of the acid to ten of the ointment, is an efficient remedy in psoriasis. This disease has heretofore been found rather intractable and subject to frequent remissions.—*Chic. Med. Review*.

Salicylic Acid as a Remedy for Corns.

TRAILL GREEN, M. D., of Easton, Pa., contributes the following to the *Med. and Surg. Reporter*:

I wish to call the attention of our profession to Mr. Gezou's remedy for corns, which you published in your journal, July 17, 1880, p. 63. In the "Transactions of the Medical Society of Pennsylvania" for the year 1876, p. 283, I reported the use of salicylic acid in the treatment of corns. I used it first in the treatment of soft corns, but very soon found it would remove hard ones as well. I applied it on cotton, and I can testify to the certainty of the effects of salicylic acid in the treatment of these painful excrescences on the toes.

It occurred to me, when I read Mr. Gezou's prescription, that the collodion which he employed to dissolve the acid would keep it well applied to the corn, and I have used it as prepared by him, in a great many cases, since July, 1880, and, I can say, with constant success.

The collodion, as already mentioned, fixes the acid on the diseased part, and gives speedy relief by protecting it from friction. The cannabis indica acts as an anodyne, and the acid reduces and loosens the corn, so that it comes off in four or five days, adhering to the collodion. The remedy is applied with a camel's hair pencil, and, if the corn is not well cured, the application may be repeated. In four or five days the patient should use a warm foot-bath and rub off the collodion. If any portion of the corn remains the acid should be applied again, and the treatment continued until the whole of the corn has disappeared. The skin will be soft and smooth, as in the healthy state.

I have used salicylic acid in the treat-

ment of bunions with like good results.

Collodion as found in the shops makes a good mixture, but I have found Dr. Edward R. Squibb's flexible collodion preferable, as it makes, with the other ingredients of the remedy, a denser fluid. The extract of cannabis should be the solid extract.

M. Gezou's formula, as given in the *Reporter*, is:

℞. Salicylic acid, 30 parts or grs. xxx.; ext. cannabis indica, 5 parts or grs. v.; collodion, 240 parts or f 3 ss.

Mask Treatment of Eczema.

In the *St Louis Med. and Surg. Journal*, Dr. R. W. WILCOX says, eczema of the face and head, so common in children, in many cases fails to be relieved, for the simple reason that the applications are not closely applied to the diseased surface. To remedy this deficiency a mask is here in use, a piece of cloth, with holes for the eyes, nose and mouth, with slits for the ears, to assist in keeping it in position. The ointment is to be thickly smeared over the mask, and it is to be worn constantly, only being removed as lotions are being applied. This treatment effectually prevents the scratching, which so thoroughly thwarts all endeavors. Any ointment can be used, but for the most part, diachylon, very carefully made, is selected. In something the same way a skull cap can be made, the inside of which smeared with the ointment, can be used for eczema of the head.—*Med. and Surg. Reporter*.

Viola Tricolor in Eczema.

Dr. H. G. PIFFARD (*Medical Record*), is inclined to believe that *viola tricolor* is a specific in eczema, in the same sense

that quinine is a specific for ague. He uses a fluid extract prepared by Squibb; the dose being, in adults, from five to ten minims in acute eczema, and from half a drachm to two drachms in sub-acute and chronic eczema. The drug should be taken in water once, twice, or thrice a day, always on an empty stomach, and when possible, half an hour before meals.—*Chic. Med. Review*.

Treatment of Eczema.

Dr. LASAR recommends that the parts be well soaked in oil rendered antiseptic by the addition of one to two per cent. of carbolic acid, or of Salicylic acid, or one and half per cent. of thymal. Sometimes the carbolic acid can be borne only for a short time, as it will of itself produce eczema. The thymolized oil is especially useful in rheumatism and erysipelas, and it has been used in burns. Sepesed oil may be used in place of the more expensive olive oil, and drying oils, such as linseed oil, are to be avoided, as they may cause inflammation. In chronic eczema, especially in infants, and in eczema of the face, he recommends an ointment. The formula for an ointment in eczema of the face, which cannot be rubbed off during sleep, is: ℞. Salicylic acid, 3 ss.; oxide of zinc, 3; Starch, āā, 3 viss; vaseline, 3 xij.—*Louis Med. News*.

Startins Mixture.

For reducing cutaneous congestion in erythema, urticaria, etc. ℞. Sulphate of iron, one part; sulphate of magnesium; tincture of gentian, āā 8 parts; dilute sulphuric acid, 2 parts; water, 24 parts. M. Sig.—A teaspoonful to be taken after eating.—*New Remedies*.

Ring Worm.

Dr. J. V. SHOEMAKER recommends the olate of copper in ring worm. The

oil is to be rubbed thoroughly night and morning with the olate. The oleic acid, in combination with the copper, has a more decided action in penetrating the hair follicles than any other remedy the doctor has used.

Cutaneous Lymphadenitis.

Dr. L. GALLIARD presents, in the *Annales de Dermatologie et de Syphiligraphie*, March 25, an outline of the history and of the pathological changes characterizing this cutaneous disease, together with extended notes of a case observed by himself. Ranvier first demonstrated the origin of the disease, and declared it to be a manifestation of the lymphatic diathesis, although Albert and Basin studied it before him. The new growth is often preceded by areas of evanescent cutaneous congestion, by erythema, pruritus, or by lichen. The neoplasms grow very slowly, may be transiently retrogressive, often occasion no visceral metastases, and do not end in leucocythæmia. They occupy by preference the internal aspect of the limbs, the anterior surface of the trunk, and the frontal region. Their size varies from that of a pea to that of a large nut. Their consistency is soft, their color grey, and their surface marked by capillaries of large calibre. The neoplasms are developed in the cutis, and cause tension and projection of the epidermis. They soon produce ulceration of the latter, and discharge sanious and fetid pus upon the surface. Microscopical examination shows the tumours to be composed of reticulated fibrous tissue, the interspaces of which are filled with lymphoid cells. In spite of the slow development of these new growths a cathetic state established, the patient suffers from grave anæmia, the discharge from the tumours is exhaustive, and the

termination is usually lethal.—*Med. Record.*

The Pathology of Lupus.

Dr. E. S. SHURLEY, of Detroit, read a paper before the last meeting of the American Laryngological Association entitled "Lupoid Ulceration of the Nasal Septum," in which the pathology and treatment of lupus were considered with especial reference to its appearance in this locality. The paper was based upon the study of four cases of ulceration, more or less destructive, of the nasal septum, one of which was accompanied with veritable lupus of the skin, while the others were not. The clinical history, carefully obtained, showed in neither case a syphilitic taint. The conclusions summed up by the writer were—that lupus, when its pathogeny and pathology become more thoroughly studied, will probably be considered a scrofulous manifestation; that lupoid ulceration often simulates syphilitic ulceration so closely as to be with great difficulty differentiated; that lupus will sometimes occur in the nasal mucous membrane primarily, and without any invasion of the skin; that the general healthy condition of the patient is not necessarily affected by such ulceration, even when quite extensive; that such ulceration does not depend upon any form of syphilitic poison for its progress, and that its cure or arrest may generally be brought about by those plans of treatment, both local and constitutional, known as antiscrofulitic. In the management, special attention was called to the use of iodoform and thymol, together with cleansing solutions for topical treatment, and the administration of iodine or its preparations internally.—*Med. Times.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

The Treatment of Fracture of the Skull with Depression.

On this important and interesting subject the *Lancet* makes the following remarks :

It is not improbable that in the operative treatment of injuries and diseases of the skull, some of the most important advances in surgery in the immediate future will be made. We now operate freely on deformed bones and diseased joints; operations on the abdominal viscera are now undertaken, which but a few years ago were looked upon as altogether beyond the bounds of the practicable; and the therapeutic advances that have made these procedures so successful may be equally well applied to the surgery of the head. But accuracy in diagnosis is an essential condition of successful treatment, and as the recent discoveries of the special function of individual portions of the surface of the brain are rendering exact diagnosis of superficial brain lesions possible, it is not rash to foretell that surgery will keep pace with the science of diagnosis. The surgical treatment of depressed fracture of the skull has been formulated into the proposition that when accompanied with evidence of compression of the brain, an operation to remove the depressed bone should be undertaken at once. This is the general if not the universal practice among British surgeons. But latterly, some inclination to extend the use of the trephine has shown itself in more than one quarter. The reasons for this exten-

sion are that the operation, when properly conducted, and especially when carried out with due precaution against septic infection of the wound, is not a very dangerous one, and if we may argue from Dr. Yeo's experiments on monkeys to man, we may say that the use of the trephine adds very little, if at all, to the gravity of a case. Again, surgeons from time to time see cases where the results of a post-mortem examination show that a life might have been saved by a timely use of the trephine. In Paris the doctrine was first promulgated that the trephine ought to be used in *all* cases of *compound* fracture of the vault of the skull, whether actual depressions of bone, or symptoms of compression, be present or not. And lately in America, it has been urged by Dr. Gunn that in *all* cases of depressed fracture, with or without symptoms of compression, and whether simple or compound, the depressed bone should be elevated. While we fully believe that the operation of trephining has fallen into undeserved disrepute, and might with advantage be resorted to more freely, we think that Dr. Gunn's proposal is unsound and dangerous. It is a familiar fact to any surgeon of large experience that patients who have received depressed fractures go through life quite unaffected by them, and while such is the case no appeal to cases in which the course of events is different ought to induce a surgeon to submit all cases alike to operation. For there is not conclusive evidence before us that the evil effects of depressed fractures, which often arise, may, without giving rise to symptoms, advance to such a degree as

to render trephining useless. There appears, then, to be no sufficient ground for formulating the rule of practice otherwise than as at present, but it should be more liberally interpreted, close watch for symptoms of local mischief should be kept up, and the trephine resorted to as soon as any such symptoms declared themselves, even though slight, and with strong hopes of a successful issue, instead of, as at present, looking upon it as a *dernier ressort*, and using it timidly and with gloomy foreboding.—*Med. & Surg. Reporter.*

Abscess of the Brain Following Fracture of the Skull.

Dr. J. H. SHORTER, of New York, communicates the following interesting case: Jenny I—, aged three years, of good personal and family history, was first seen on July 9th. On July 6th she had slipped, and, falling forward, had struck on a piece of kindling wood which she held in her hand. She did not seem stunned much by the blow, which was inflicted just below the superior edge of the left orbit. There was no apparent injury of the globe, and only a contused wound of the upper lid, with but slight abrasion. Such was the report of the parents, who insisted that the piece of wood, which had blunt, square ends, did not penetrate the skin at all. On July 9th there was œdema and puffing of the upper lid, and some exophthalmus; the child seemed to suffer from pain. The parents would consent to no operative procedures whatever. On the 11th the local symptoms were worse and constitutional disturbances very well marked. From a state of lassitude the patient gradually fell into a stupor. On the 12th, the little one being in the condition mentioned, a deep incision was made immediately below the upper edge of the orbit, and

a large amount of pus evacuated. Marked amelioration of the symptoms followed. On examination with the finger passed through the external opening, a fracture of the orbital plate of the frontal bone was discovered, of rectangular shape, 25 by 12 mm. in size. The fragment of bone seemed to be driven upward, and the diagnosis of meningeal and probably cerebral laceration also was made. Two days later the temporary improvement of the symptoms was succeeded by a relapse. Dr. Sabine, aided by Drs. Gruening and Oppenheimer, then removed with great difficulty a piece of bone which was tilted upward perpendicularly into the brain substance. Subsequent syringing of the cavity of the wound with a one per cent. solution of carbolic acid caused immediate improvement, restoring consciousness and reducing temperature from 105° to $102\frac{1}{2}^{\circ}$. The symptoms remained fair till the fourteenth day, when spasmodic jerking of the left shoulder set in; later there was diaphragmatic spasm, much restlessness and groaning. On the sixteenth day the temperature was found to be much lower on the right side than on the left ($102\frac{3}{4}^{\circ}$ and $104\frac{4}{5}^{\circ}$ respectively). This difference remained to the last. Abscess of the brain being determined upon as the probable cause of the continued bad symptoms, Dr. Shorter passed a trocar up almost perpendicular into the anterior lobe of the cerebrum through the opening of the fracture. Some serum but no pus escaped; no improvement was apparent. Patient died the next evening.

The autopsy revealed a general meningitis, and on dissection an abscess cavity the size and shape of a pigeon's egg, occupying the anterior part of the left hemisphere, but not communicating with the wound in the orbital plate or the surface of the brain. The trocar

had passed within a millimetre of the abscess and entered the ventricle. A piece of bone similar to but smaller than that removed was found attached to the opening and projecting upward into the brain. The case is of interest as showing that injury may occur to this thin bone, consequently to the brain substance, without perforation of the skin or soft tissues. It also shows the importance of the early removal of collections of pus around the orbital cavity.—*Med. Record.*

Compound Fracture of Both Arms.

Mr. E. DOWNES reports, in the *Lancet*, the following case which occurred in the Kashmir Mission Hospital: A boy, about fourteen years old, met with an accident by which both bones of both arms had been broken one and a half or two inches above the wrist. After receiving the injury he walked twenty miles and received no treatment for ten days. Upon entering the hospital the wounds on both arms were dirty and stinking. There were two wounds, one for each bone, and the right hand was swollen, and pus could be pressed up into the wound from the palm. The large blood vessels appeared uninjured. After the wounds had been cleansed the ends of the bones were sawn off and the limbs were put in bracketed splints, dressing the wounds with lint and carbolic oil. For two weeks the boy lived in great agony, opiates failing utterly to relieve his suffering. Finally improvement came; the discharge became more healthy, the hands looked more natural, pain diminished, and appetite improved. After six weeks union was noted. From time to time it became necessary to slit up sinuses into which pus had burrowed. He was discharged after two months and a half; at this time the fingers of the right hand

were not of much use and the left hand was somewhat stiff; he could, however, flex the hand and fingers; he could even hold a stick with his left hand, though the grasp was not firm. This case serves to show what can be accomplished by conservative surgery.—*Med. and Surg. Reporter.*

Old Dislocation of Femur Reduced by Manipulation.

At the York County Hospital, England, a farm-laborer who had experienced a dislocation of the femur, backwards, was admitted eight weeks after the accident. On the day after admission, Mr. Jalland reduced the dislocation by manipulation, there being no adhesions. The patient was fully etherized. He was afterwards put in bed, with a long lateral splint on the limb, and at the end of a week a plaster bandage was applied, and he was allowed to get up on crutches. He was discharged three weeks later, with a perfectly movable joint.—*British Medical Journal.*

Complete Lateral Dislocation of the Elbow Joint.

Dr. OSCAR LEEDOM (*Med. & Surg. Reporter*).

A short time back the following case came under my notice: H. C., a large, bony man, was driving a colt to a dog-cart, when the colt shied off to the side of the road and threw him from the cart. In his fall his left arm was caught in the wheel and a complete outward dislocation of both bones of the forearm produced. I saw him about an hour after he received the injury. Having placed him well under the influence of ether, I made a careful examination of the joint, when I found the following condition of things: The radius and ulna were both dislocated from their articulating surfaces on the humerus. The olecranon

was twisted around nearly in front of the joint, passing completely over the external condyle, while the head of the radius was dislocated forward and inward, the cup-shaped extremity of the head of the radius being easily felt through the integument of the arm. With the assistance of my father, Dr. Edwin C. Leedom, I succeeded in restoring the displaced bones to their proper position. We were unable to detect any fracture, both bones appearing to be intact. Nearly all the authorities who have written on this subject agree in saying that the most common cause of this accident is a blow upon the inner side of the forearm or the outer side of the humerus, or from the action of two forces pressing upon the arm in opposite directions in close proximity to the joint. A fall upon the hand is said to have produced it, which I think must certainly be a mistake. I do not see how a fall upon the hand could possibly produce such an injury. I can readily understand how it might be produced by two forces pressing in opposite directions near the joint, one upon the outside of the humerus, the other upon the inside of the forearm. But it seems to me that the most usual cause of this injury would be a violent twisting, such as this man's arm received in the wheel, or the twisting caused by revolving machinery. So far as I can learn, a complete internal dislocation has never been recorded. The force applied in this instance must have been very great, and the laceration of ligaments about the joint considerable; nevertheless, the patient made a good recovery, although there is some loss of motion and stiffness in the joint. This case was one of unusual interest to me, not only on account of the rare form of the injury, but because it seemed to me almost impossible that the ulna could be so twisted

around without sustaining a fracture of the olecranon; yet such was the case.

Diagnosis of Cerebral Contusion.

M. DUPLAY (*Le Progrès Médical*), distinguishes between the signs of commotion of the cerebral substance from an injury and these properly belonging to contusion of the brain, which are generally confounded or grouped together. He concludes that in some cases we may suspect contusion in an individual who, at the same time with the symptoms of commotion, presents convulsions, contractures—say of the muscles of the face—or paralysis of one side of the body, or of certain muscular groups; but in the majority of cases, and for a certain length of time, in order to affirm the existence of a contusion, it will be necessary to await the inset of symptoms of inflammation. The signs that have hitherto been given as belonging to contusion of the brain by all writers upon the subject are mainly those arising from commotion of the brain. Contractures of muscles which are more or less general—*i. e.*, not definitely localized so as to correspond with lesions of the well-known cortical centres, however, are probably due to irritation of the nerves of the dura-mater, a condition also capable of explaining certain vascular reflexes, such as spasms or congestive paralysis of the vessels of the cerebral hemispheres or of the optic globes. This point should be borne in mind in the diagnosis from the ophthalmoscopic appearances of the retina, in order not to attribute to cerebral disease what in reality is due to congestion on inflammation of the meninges.—*Med. Times.*

The Antiseptic Treatment of Wounds.

Dr. W. T. BRIGGS submitted the following conclusions regarding this sub-

ject at the American Surgical Association :

First.—The germ theory of wound infection is not established.

Second.—The antiseptic treatment of wounds after operations and injuries is not limited to Listerism or any other special method, but is based upon broad general principles.

Third.—Antiseptic surgery embraces every condition or agent that tends to prevent putrefactive changes in wounds, or to remove or neutralize the evil effects of such changes when they have occurred.

Fourth.—All wounds are healed by reparative inflammation.

Fifth.—All wound accidents are the result, either directly or indirectly, of destructive inflammation.

Sixth.—The antiseptic treatment of wounds, properly considered, consists, first, of such means as will restrain inflammatory action within reparative bounds ; and second, of such means as will subdue excessive action, and remove or neutralize the effects of destructive inflammation.—*Med. Record.*

Dr. Byrd on Surgery.

The following is an extract from Dr. BYRD'S address on Surgery, Excisions of the Alimentary Canal, etc., at American Medical Association :

The history of excisions of portions of the alimentary canal by the surgeon, dates back but a few years, and may be said to be the result of evolution beginning with McDowell's first ovariectomy. In cases of obstruction from stricture, medicine had failed for ages to afford relief, and surgery offered no hope. Occasionally where the constriction was caused by the strangulation of an extended bowel in hernia, the intestine would slough and be thrown out through an abscess, and nature would form an

artificial anus. The great fear of entering the peritoneal cavity deterred the surgeon from hoping for anything better or resorting to any more radical means for the relief of the poor sufferers. Dr. Nicholass Senn, of Milwaukee, in a very able and exhaustive report to the Wisconsin State Society on the recent progress of surgery, says : The results of the cases of excision of the stomach may not seem promising, but when we come to review the earlier history of anatomy the picture is nearly as dark, and it must be taken into consideration that many of these operations were undertaken after extensive adhesions had formed and neighboring tissues become involved. May we not hope with earlier and more accurate diagnosis that the diseased mass may be removed so as to restore the patient to years of health and usefulness ? The details of the technique of the operation are so well described in a report of Dr. F. J. Lutz to the St. Louis Medical Society and published in June, 1882, that I forbear to quote. The remarks of the late Dr. John T. Hodgen relative to the operations were quoted in length. From the cases and the analogous ones which the author has studied he draws the following conclusions :

1. Resections of the small intestine may be done to a considerable extent without interfering in any appreciable degree with digestion.

2. Practiced under suitable conditions the operation is to be considered perfectly legitimate.

3. The resection may be performed by bringing the divided ends directly into opposition and closing the abdominal wound, by forming an artificial anus. The second and third procedure expose to less subsequent danger.

4. Resection of fibrous and cicatricial structure which are probably more fre-

quent than is generally supposed may cause a radical cure, and the same is the case with epithelioma. On the contrary, resections of cancerous obstructions gives only temporary relief, and at a greater risk.

5. By proper diet after the operation the risk of fecal extravasation may be reduced to a minimum, and the best diet for this purpose is one containing as little fluid as possible.

6. By introducing liquids per anum, and drink in the same way, water is absorbed as by the mouth and there is no sense of thirst; the flow of intestinal fluids is less considerable and the patient is more comfortable.

My first case was that of a farmer at Seehorn, Ill., aged fifty-five. For years he had been treated for strangulated inguinal hernia, which could not be reduced.

Found him with clammy sweat, almost pulseless and unconscious. Cut for the hernia and found eight inches of the ileum and a piece of omentum the size of my hand gangrenous. The bowel had separated at the junction of gangrenous and living portions, permitting extravasation of fecal matter. The omentum was ligated just above the gangrenous portion and the gangrenous part cut off. The ends of the ligature were left long so as to hang out of the wound. The sound omentum was dropped into the abdomen. The two ends of the bowel were stitched into the abdominal opening so that any fecal matter would be passed to the outside. They resembled to some extent the muzzle of a double-barreled gun presenting at the opening. The opening was left large enough to permit the insertion of the nozzle of a syringe into the abdominal cavity so that it might be washed clear of any bits of fecal matter or inflammatory products. The cavity of

the abdomen was syringed out with tepid water, a teaspoonful of table salt and carbolic acid to the gallon, night and morning. Quinine and nourishing diet was ordered liberally. The patient rapidly recovered, and two months later was operated on for the cure of the artificial anus. * * * * *

Heretofore the closure of the artificial anus in many cases has been looked upon as a very difficult thing to accomplish, but I think the plan devised for its cure will make the cases few indeed where it cannot be done.—*Detroit Clinic.*

Chronic Ulcers.

The following is the treatment followed in the Notre Dame Hospital, Montreal (*L'Union Medical*). In cases of ulcers of long standing, the nutrition of the skin in the neighborhood of the ulcer, is generally at fault, the blood there stagnates more or less, and causes in a great degree the difficulty in effecting a cure. Many modes of treatment have been tried according to the requirements of each case. Compression applied with the limb elevated, has given the best results in ulcers of this kind. The compression is applied by means of a roller, the wound having been previously dressed with carbolic acid or oxide of zinc ointment, and covered over with a thick layer of wadding, over which is placed another covering of pasteboard, for the purpose of equalizing the pressure. When the discharge is too exuberant, or when there is much redness or flabbiness, the edges may be cauterized with nitrate of silver, and powdered alum applied to the surface of the wound. The red lotion generally constitutes an excellent application, when the ulcer secretes a great quantity of pus. It will also be found beneficial to replace the ordinary wadding by absorbent cotton, which absorbs the excess of pus, and

prevents it flowing over the edges of the ulcer. In certain cases of large ulcers marked success has attended the use of the rubber bandage, applied once a day, the limb having been previously covered with a thick layer of wadding.—*Can. Lancet.*

Sulphide of Carbon and Iodoform in Phagedænic Ulceration.

From the *Revue Médicale* we note that Dr. J. CHÉRON, at the Hospital of Saint Lazare, employs the following solution: Sulphide of carbon, 30 parts; iodoform, 5 parts. Iodoform dissolves readily in carbon sulphide, and the rival odors are mutually weakened by association. The pain is less severe than when the sulphide of carbon alone is applied, and it ceases as soon as the liquid has evaporated. It is best applied with a glass brush. Dr. Chéron has seen cicatrization speedily result in cases which had proved rebellious to all the usual treatments.—*Med. & Surg. Reporter.*

Treatment of Hydrocele and Serous Cysts In General by the Injection of Carbolic Acid.

Dr. LEVIS states that he has been experimenting with a view of determining what substance may best secure the obliteration of the secreting surface, and the adhesion of the walls of the cyst with the most certainty and the greatest freedom from suffering and danger. Having selected carbolic acid as an agent which would provoke simply a plastic inflammation, he injected one drachm of the deliquesced crystals into the sac of a large hydrocele. The new procedure was entirely painless. A sense of numbness alone was experienced, and no inconvenience was felt until, on the next day, the desired inflammatory process developed. A nine

years' hospital and private experience leads the author to believe that this method is the most satisfactory for the object. For the purpose of injection, crystalized carbolic acid is maintained in a liquefied state by a five or ten per cent. solution of either water or glycerine; the crystals are to be reduced to the fluid state with no more dilution than may be necessary for this. After tapping, inject with a syringe having a nozzle sufficiently slender and long enough to reach entirely through the canula. He has never been able to detect any general toxic effects upon the system, but believes that the action of strong carbolic acid on surfaces secreting albuminous fluids is to seal them, to shut them off from the system in such a way that absorption cannot readily take place. The occluding influence of strong carbolic acid he regards as an important surgical resource in certain cases of compound fracture, destructively lacerated wounds, and ulcerating surfaces, where septic infection is inevitable. All forms of serous cysts which are usually subjected to any form of operative treatment, on the principle of producing plastic adhesion of their walls, may be deemed amenable to the treatment indicated.—*Medical News.*

Antiseptic Treatment of Abscess.

Dr. LUCAS CHAMPIONNIERE (*Union Médicale*):

Before opening an abscess, in whatever region it may be placed, we should carefully wash the skin, especially if it has been covered by a poultice, with a strong carbolic acid solution:

℞. Acidi carbolic, fifty parts; glycerini, seventy-five parts; aquæ, one thousand parts. M.

The bistuary should also be dipped in the solution. The contents of the abscess are to be discharged, and some

of the above solution injected, care being taken that the injected liquid has a free issue. The end of a caoutchouc tube is introduced into the wound, having a thread attached to it to facilitate its removal, and it is then covered by a thick layer of charpies impregnated with a solution of carbolic acid twenty-five parts; glycerine, twenty-five parts and water, one thousand parts. Finally, over all is laid a layer of gummed silk. At the end of twenty-four hours the tube is removed in order that it may be cleansed and shortened, when it is again covered with the charpies moistened with the weaker solution. Under this treatment the amount of suppuration is diminished, the redness of the wound becomes insignificant, and the cicatrices which result are much less apparent. Dr. Lucas recommends this procedure especially in abscess of the breast — *Med. & Surg. Reporter*.

Hydrocele Treated Radically.

Clinic of JOHN ASHHURST, JR. (*Medical Bulletin*):

Our next case is a man with a scrotal tumor, of some seven months' duration. It has increased in size, and is of an elongated shape; the lower part is pyriform in appearance, and there is also some enlargement above, giving the whole tumor somewhat the appearance of a dumb-bell.

It is elastic and fluctuating, and by balancing it upon the hand it seems very light in comparison with its bulk. This would lead us to infer that its contents were of a fluid character. Hydrocele may be mistaken for hernia, or for a solid tumor of the testicle. The latter usually has its greater diameter in the other direction, and often involves the cord to a considerable extent, rendering it thickened and indurated.

If this were a case of hernia we should have impulse on coughing, but there is none, as you see. By invaginating the scrotum we find that the inguinal canal is free, and that there is no intestine present, and the inference is that the case is one of hydrocele. The treatment we propose to adopt is first to evacuate the fluid and then inject pure tincture of iodine. In tapping a hydrocele always see to it that the trocar slips easily in the canula; this may save considerable annoyance. Avoid any superficial veins, and then make a quick perpendicular thrust, preventing injury to the testicle by inclining the point of the trocar upward as soon as it has entered the sac. You see now the characteristic amber-colored fluid of hydrocele. We shall be able to empty this sac from one puncture, but sometimes a hydrocele is multilocular, when more than one puncture will be required.

In injecting the iodine, proportion the amount to the size of the tumor, using from one to three fluidrachms of the tincture, according to size. You should leave the iodine in the sac itself. Some surgeons withdraw the fluid and some inject dilute fluids. I do not advise this, but prefer Syme's method, using a small quantity of the pure tincture, and allowing it to remain in the sac.

If the iodine gets into the cellular tissue of the scrotum it may excite suppuration. We do not desire suppurative of the tunica vaginalis or of any part of the scrotum. We wish to excite inflammation of the tunica vaginalis, and, perhaps, by the formation of inflammatory lymph, get adhesion of its opposing surfaces. It is commonly believed by surgeons that unless adhesion of the two surfaces of the tunica vaginalis takes place there is no cure. This is not so; in many cases there is no adhesion, but some change in the serous

structure is brought about, preventing further exudation. There will be considerable pain and swelling following the operation, but the swelling will subside in the course of a few days, when we will begin strapping the part with adhesive strips, which will hasten the progress of the cure.

The Treatment of Carbuncle.

Dr. S. BARUCH, M. D.: There are few diseases which have been subjected to more varied methods of treatment than carbuncle.

The crucial incision, with its various modifications, so glowingly advocated by Syme, Collis and others, has had its day, and, together with the depleting measures, has passed into desuetude. Regarded as a disorder due to or accompanied by conditions of debility, there is now little difference of opinion with reference to the admissibility, nay, the necessity, of general and local supporting measures.

In the course of an experience of twenty years the following treatment of carbuncle has gradually developed into a successful mode of management:

Beginning with the classical crucial incision, I did not fail to recognize its great utility in the amelioration of pain. I have no doubt that I have transposed patients from the throbbing agony so characteristic of carbuncle to a condition of great comfort by freely laying open the tense and brawny tissues. But the relief was temporary, the disease was not checked, the loss of blood from the turgid vessels occasionally prostrated the patient, and altogether the result offered an analogy to the depleting treatment formerly adopted in pneumonia.

In fact, the analogy between the management of the latter disease and the

management of carbuncle struck me as time passed on.

In August, 1863, Dr. Prichard published in the *British Medical Journal* an article in which he suggested the value of collodion combined with iodine and iod. potass., as a support, with absorbent action in carbuncle. Pressure by strips of adhesive plaster has been advocated by some, but in my experience the collodion which I have long used without iodine is superior, inasmuch as it adapts itself to the uneven surface of the tumor, and, by gradual compression, supports the parietic coats of the vessels, aids in expelling the liquid detritus, and affords comfort to the patient which is remarkable. I have often noticed, after the crucial incision, liquid and semi-solid matter oozing from the exposed surface so soon as the collodion began to contract. The hemorrhage, too, was moderated, and the relief from tension, inaugurated by the incision, became more lasting.

For the next improvement in the treatment of carbuncle we are also indebted to an Englishman. In "Braithwaite's Retrospect" of July, 1871, Dr. Murray recommended the use of potassa fusa in lieu of the incision. This caustic had been formerly recommended for the purpose of avoiding the pain of the incision and facilitating the sloughing. But Dr. Murray presented it for a different purpose, viz., to abort the carbuncle, and I can testify to the success of the "crucial scoring" of the unbroken surface of a beginning carbuncle. When a patient presents himself in the incipient stage, ere vesicles are fully formed, I apply the solid potassa fusa in two crucial lines, gently rubbed into the tense integument as far as the dusky discoloration extends. Even when the vesicles are formed, but before sloughing has commenced, this crucial scoring

will be useful; but the pain resulting from it in these cases has deterred me from frequently resorting to it. Collodion is next brushed in three or four successive coats upon the diseased surface, excluding the crucial lines. A light flaxseed poultice, warm and soft, is applied over the whole, and in many instances the relief is marvellous. Pain ceases at once. In a few days the central portion of the tumor sinks, a thin tegumentary slough separates, and the carbuncle seems to melt away.

In more advanced cases a different course is pursued. The recommendations of Dr. Eade, of London (who regards carbuncle as a parasitic disease), to introduce carbolic acid within the tumor, has proven a boon to me in these trying cases. The pure carbolic acid, liquefied, and held in liquid form by a few drops of glycerine, is frequently carried by means of a camel's hair brush into every open point, after the slough channel has been cleansed by a pointed tent of linen. This application must be made thoroughly, but very gently. If properly done the pain will not be severe, and its daily repetition, which is necessary, will not be dreaded by the patient. After this application, collodion is freely brushed in three or more successful coats over the entire diseased surface, extending a few lines beyond the outline even. A doubled piece of linen, having a central opening to admit the sloughing portion of the carbuncle, is now laid upon the collodion-covered surface. A light flaxseed poultice is placed over the former, and renewed several times a day. Tincture of iron and quinine, milk, any other nutriment the patient can be induced to take, are freely administered, anodynes are prescribed whenever necessary, with a view to allay pain and prevent loss of sleep. The latter are rarely needed after the

first day. If the case progresses favorably, the collodion dressing is continued daily, but the carbolic acid may be omitted every other day. Patient is urged to go out into the open air, or to be carried out, when unable to move, without pain.

Under this management carbuncle may be carried to its termination, with a minimum of pain to the patient and a maximum of satisfaction to the surgeon. —*Ame. Med. Bi-Weekly.*

The Pre-Cancerous Stage of Cancer.

Mr. JONATHAN HUTCHINSON makes some valuable remarks on this subject in the *British Medical Journal*. He believes that if properly treated in its incipency there is a very good prospect of curing many cases of cancer. "Too late! Too late!" is the sentence written but too legibly on three-fourths of the cases of external cancer concerning which the operating surgeon is consulted. The bitterest reflection of all is, that usually a considerable part of the precious time which has been wasted has been passed under professional observation and illusory treatment. He never loses an opportunity to enforce the doctrine of the local origin of most forms of external or surgical cancer and the paramount importance of early operation. All suspicious sores should be considered syphilitic, and treated internally by iodide of potassium and locally by caustics, until the diagnosis becomes clear. In most cases of cancer of the penis, lip, tongue, skin, etc., there is a stage, often a long one, during which a condition of chronic inflammation only is present, and upon this the cancerous process becomes engrafted. Phimosis and the consequent balanitis lead to cancer of the penis; the soot-wart becomes cancer of the scrotum; the pipe sore passes into cancer of the lip; and the

syphilitic leucoma of the tongue, which has existed in a quiet state for years, at length, in more advanced life, takes on cancerous growth. A general acceptance of the belief that cancer usually has a pre-cancerous stage, and that this *stage* is the one in which operations ought to be performed, would save many hundreds of lives every year. What is a man the worse, if you have cut away a warty sore on his lip, and when you examine sections microscopically you find no nested cells? You have operated in the pre-cancerous stage, and have probably effected a permanent cure of what would soon become an incurable disease. Instead of looking on while the fire smoulders, and waiting till it blazes up, we should stamp it out on the first suspicion. He does not wish to offer any apology for carelessness, but he has not in this matter any fear of it.

DISEASES OF THE EYE AND EAR.

Photophobia from Sexual Exhaustion.

In sexual exhaustion too little attention has been paid to the eye, not only for itself but as a means of diagnosis. In a typical case something like the following will be noticed: The eye often is perfectly normal for a few seconds of use, but tires with wonderful rapidity. The fundus of the eye shows no special lesion beyond perhaps a little anæmia. The most marked symptom is the photophobia. By suddenly throwing a strong light upon the eye, the patient not infrequently will start back as though struck by some sharp instrument, the eyelids closing spasmodically, and the muscles taking minutes to regain their equilibrium of tone. Another point may often be noticed, and that is a slight spasm of some of the fasciculi of the orbicularis, just beneath the eye, which

looks as though the individual were trying to wink. Again, upon closure of the eyes, the whole of the orbicularis often twitches and trembles like the muscles of paralysis agitans. The diagnostic bearing of these facts is of course only presumptive. If a patient be found suffering with the above symptoms, and no definite cause for it, the safe plan is to investigate the sexual life, for we may rest assured that no local means are of avail. The appearance and attitude of the patient are suggestive. The position of a man with a broken clavicle is familiar to all, and something similar is seen in these cases. The hyperalgesia of the retina makes the patient dejected and timid. Without any other treatment than rigid hygiene and appropriate tonics the above symptom rapidly disappears.

Aural Vertigo.

In a paper read before the Philadelphia County Medical Society, Dr. C. H. BURNETT presented the following conclusions on aural vertigo:

There are two sets of fibres in the auditory nerve, viz., the sensory and the motor.

The motor filaments are connected on one side with the cerebellum by means of the inferior peduncles, and on the other side with the nerve-filaments sent to the ampullæ of the semicircular canals.

Irritation of these ampullar nerves may be conveyed from either of the three parts of the auditory apparatus, or from the auditory nerve itself, in the mechanical form of pressure, and this irritation may be further conveyed to the cerebellum and cause vertigo; so that it logically follows that this reflex cerebellar phenomenon as produced by aural irritation should receive the general denomination of *aural vertigo*, and that Ménière's disease is only a form of aural

vertigo. Hence the latter name, unless used after accurate diagnosis of a disease originating in the labyrinth—*i. e.*, in the semicircular canals—will create confusion. But it should be said, in justice to Ménière, that, so far as the writer knows, he has never claimed a general application of his name to all forms of aural vertigo. It has been so applied only by well-meaning but inaccurate diagnosticians. — *Philadelphia Medical Times*.

Strumous Ophthalmia.

Dr. C. H. BROWN (*Med. & Surg. Reporter*).

The physician is often called upon to treat cases of strumous ophthalmia, children of a strumous habit, who suffer with sore eyes, and perhaps other evidences of scrofula, but in which the unpleasant condition of the eyes is the most prominent symptom. The lids are red and swollen, with numerous and frequently recurring minute pustular collections about the lashes, with some conjunctivitis and photophobia, etc., not only giving the eyes a very unpleasant appearance, but also preventing the patient from using them with any degree of comfort.

In these cases, in addition to the local treatment as sketched above, the internal use of sulphide of calcium is almost a specific. The good effects resulting from the use of sulphide of calcium in scrofulous sores, suppurating glands in the neck, and similar affections occurring in connection with this strumous diathesis, have been known for some time, this use of the remedy having probably been brought to the attention of the profession by Dr. Sydney Ringer; but it is of more recent date that it has been recommended in cases of blepharitis and strumous ophthalmia.

I have employed it in a number of

cases and with very satisfactory results; and, although my experience with it has not been sufficiently extended to be able to express a decided opinion, yet I feel that this remedy is destined to be a valuable one in the treatment of this class of cases. The testimony of others as to its efficacy is being gradually collected, and sulphide of calcium is assuming a high place in the therapeutics of strumous ophthalmia, blepharitis, phlyctenular keratitis, etc.

Of course, there are some cases it will fail to cure, but it often happens that the exception proves the rule. There are some cases of ague that quinine fails to cure, and yet no one doubts the value of quinine in the treatment of ague. But even though there are some cases of strumous ophthalmia that sulphide of calcium will not cure, yet I think it cannot fail to be at least a partial benefit in every case, so that it should always be given a fair trial.

The consequences of blepharitis are many and interesting: Trichiasis and distichiasis (in which the lashes turn in and rub over the eyeball); entropium and ectropium (in which the free edge of the lid is respectively inverted and everted). These diseases all call for surgical interference, and need not be considered here.

Treatment of Sycosis.

According to M. BOUCHUT (*Jour. de Connoissances Med.*), sycosis may sometimes be cured without epilation, by means of applications, made morning and evening with an unguent, of which creasote is the active element. He recommends the following formula:

R. Creasot., ʒxx ad f 3 ss; zinci oxid., 3 iss; ung. simpl. benzoat., ʒ j. M.

After each application of the ointment the affected parts should be covered with piled silk.

Optic Nerve Reaction to Mechanical Irritation.

There are many cases to be found in the literature in which, although the optic nerve was functionally active, its section was not followed by any sensation of light. SCHMIDT-RIMPLER (*Centralblatt für die Medicinischen Wissenschaften*, No. 1, 1882) has tried to obtain a specific reaction by pressing over the stump of the optic nerve in cases where the eye had recently been enucleated. Out of six cases he thus produced light flashes in two, but these flashes were produced by electrical stimulation in all, whence he concludes that a specific reaction does follow mechanical irritation if properly tested.

Potassium Iodide and Calomel in Ocular Therapeutics.

The *Archiv. für Ophthalmologie (Cincinnati Lancet and Clinic)* has an interesting paper on this topic. Various authors have noticed that bad symptoms were sure to arise if calomel were used locally on the conjunctiva while the patient was taking iodide of potassium. In every case a violent conjunctivitis was set up, but the cause of the inflammation remained unknown. Dr. SCHLÄFKE gave to a rabbit, iodide of potassium equal to one-seven thousandth part of its weight, and found that at the end of seven minutes he was able to detect this salt in the tears by its reaction to the chloride of palladium. In man when the iodide is used in doses of from fifteen to thirty grains daily it cannot be detected in the tears by the use of the salt named, but if a little calomel be placed in the cul-de-sac of such an individual there is provoked a violent conjunctivitis limited to the parts upon which the calomel has been placed. It is very easy to produce the same effect in rabbits to whom the iodide has been

given. The irritation is caused by the iodide of mercury there produced. Many opinions have been advanced as to the action of calomel when dusted in the eye. Some hold that there is a chemical action, others that the effect is purely mechanical. Clinical observation seems to uphold the first view, for inert powders do not have the same effect as calomel. Those who refuse to use calomel say a chemical change points to its insolubility, but Schläpke has shown that it is sparingly soluble in the tears, and that the proto-chloride of mercury is formed rather than the bichloride, on account of the small quantity of chloride of sodium in the tears.

VENEREAL DISEASES.

Chancre of the Lip and Epithelioma.

R. C. LUCAS, F.R.C.S. (*Can. Lancet*): Two cases illustrating the resemblance which these two affections often present have lately been attended on the same day, and a careless observer having regard only to the local disease, and ignoring the history and the age of the patients, might easily have fallen into serious error. Nor is the diagnosis always easy when no fact is omitted which might influence the conclusion; but in the two cases before us, despite the similarity in appearance, there is corroborative evidence in each case which leaves no doubt as to the nature of the disease. One patient is a man about thirty years of age and unmarried. He has the thickening of the edge of his upper lip slightly to the right of the centre. In the middle of this thickening there is a superficial abrasion upon which the secretion and epithelium cake and scale. The whole lip is a little swollen, but if you pinch it between your finger and thumb you feel a hard

circular rim to the sore about the size of a sixpence.

Now look at the other man. He is a respectable married man, upwards of fifty years of age. He has a superficial sore on his lower lip to the left of the median line. The surface is almost exactly similar to the other man's sore; it is cracked, and has a tendency to scab and scale. It, too, has a thickened rim, but if you pinch it you find the resistance less than in the other case; but so similar are the sores that, if their positions could be changed, I do not think you would be able to distinguish one from the other. Yet one is a cancer, the other the initial stage of syphilitic infection. How, then, can one distinguish them? First, the age and state of life make it probable that the young man's sore is a chancre, the old man's an epithelioma; but thirty is not too young for epithelioma, nor is fifty proof against syphilis, although with age impetuosity yields to discretion. Epithelioma below thirty-five is very rare. Last year I operated upon a man aged thirty-eight for a cancer recurrent in the cheek and glands of his neck, which had been operated on some time before in the country; but this is an exceptional case, and the age is of the greatest importance in aiding our diagnosis. Cancer occurs at the time when the tissues begin to wear out, and epithelioma especially is almost always traceable to long-continued irritation.

Next, the position is a distinguishing mark in these two cases, for epithelioma is rare upon the upper lip. The position of the sore upon the old man's lip is almost characteristic; it is just opposite the notch in his teeth made by his pipe. Further, he confessed to always having smoked an unwaxed clay. If mere contact with porous clay is sufficient, after years to set up cancer, you would con-

clude that there should be a corresponding sore on the upper lip; but the lower lip suffers most, for owing to the weight of the bowel the lower lip is pressed upon as well as rubbed.

A chancre may occur upon either lip, as it results from the virus having come into contact with a chance crack. In many cases it will depend upon whether the person is underhung or overhung; for the lip most exposed is most liable to crack, and at the same time most likely first to meet in an embrace. Hunter maintains that neither the blood nor any of the secretions could convey the poison, but this is now known to be untrue. His reasoning on this point was most fallacious. If the blood, he argued, could produce syphilitic inflammation in a healthy wound, no object affected with constitution syphilis could escape from venereal ulcers; for every time he was bled or he scratched himself with a pin the small wound thus caused would be transformed into so many chancres. Hunter overlooked the fact that the man's tissues by the inoculation were protected, for the time at least, by reinoculation, but that to another both blood and secretion might prove contagious. There is abundant evidence now of the contagious nature of the blood during the secondary stage, of the vaccine from a syphilitic infant, and of the pus from the secondary ulcers on the lips; hence there is no need to follow Ricord in his loathsome suggestions that these chancres of the lips were the result always of illicit contact.

The time during which the disease has been developing is another most important consideration in determining its character. The old man states that he has had ulceration, more or less, for five years, but that it is only during the last few months that the lip has caused him inconvenience. The other man

counts his trouble by weeks, and gives six weeks as the time since he first noticed the sore. Five years is an exceptionally long history for so small a development of epithelioma, and it is very questionable whether the sore has been epitheliomatous all this time. Rather it is probable that had he left off the irritating cause two or three years ago he might have escaped from the disease from which he is now suffering, for doubtful ulcers distinctly traceable to local irritation will often heal when relieved of the exciting cause. It is now about two years since I saw, in consultation with Dr. Orton, of Kensington, an old gentleman who had been condemned by another surgeon for cancer on the inner side of his left cheek. He was suffering from an ugly-looking ulcer with thickening edges, very like an epithelioma, but upon inquiring into the history we found that it had been noticed more than six weeks or two months, and immediately opposite we found a tooth stopped with an irregular amalgam stopping. It was clear that the ulcer was excited by the tooth, and I suggested that the tooth should be extracted, after which the ulcer completely healed. Had, however, the irritating cause been allowed to remain for months, it is highly probable that the sore in this old gentleman might have taken on an epitheliomatous character, and the medical man who first saw him would then have been correct in his diagnosis. Thus the time is of great importance in separating an epithelioma from a simple ulcer and chancre.

There is a stage in both cases when the glands under the jaw will be found enlarged; and I remember two patients came last year with sore lips, both with short histories and enlarged glands, and I refused to give a positive diagnosis till I had had an opportunity of watching

them. One of these developed a syphilitic eruption during the following week, while the other proved to be suffering from an epithelioma growing much more rapidly than the one we have now under consideration. Time will always settle the diagnosis; for it is seldom, unless the patient takes mercury, that the eruption of syphilis is delayed beyond two months. The man before us with a chancre has now upon his arms and trunk a few brownish papules, which place the diagnosis beyond all doubt.—*London Practitioner*.

Syphilis from Skin Grafting.

Syphilis from skin grafting is a possibility, as shown by a case reported in the *British Medical Journal*. Grafts were taken from several different persons, and some of them taking cicatrization, progressed rapidly, when grayish ulcers appeared, followed ten weeks after the first grafting by a roseola and subsequent syphilis. One of the contributors had a chancre a year and a half previous, with mucous patches around the anus.—*Medical Annual*.

Locomotor Ataxy of Syphilitic Origin (Specific Tabes).

VULPIAN thought that about forty per cent. of cases of locomotor ataxy were of syphilitic origin; Fournier has just demonstrated that far from being exaggerated, this statement is rather below the truth—in nearly all he finds a syphilitic source. The practical results of this view are embodied in the following conclusions:

1. In a case of locomotor ataxy seek carefully for syphilis.
2. If this diathesis exist institute severe and prolonged treatment. Endeavor to surprise the commencing

tabes, and watch the least symptom which can indicate its invasion.

3. The fear of ataxia later ought to be considered in the treatment of the initial stage of syphilis, which ought to be treated for a long time energetically.—*Gaz. Hebdomadaire and An. de Dermatol. et Syphilog.*

Ammonio-Mercuric Peptone in Syphilis.

During the past fourteen months M. MARTINEAU has made 11,000 injections in 600 patients without producing any inflammation, abscess or other bad symptom. He says that neither mercurial cachexia nor salivation is to be feared, as the mercury is rapidly excreted by the kidneys. That under this treatment the blood-cells increase in eight days to the normal (four to five millions), and there is a gain of weight to the amount of from one to five kilogrammes. A speedy result is obtained in cases of iritis and irido-choroiditis.—*Paris Cor. Lond. Lancet.*

Tendon Reflex in Secondary Syphilis.

Dr. FINGER (*Vierteljahrsschrift für Dermatologie und Syphilis*), claims that in every case of secondary syphilis coming under his observation a decided increase in cutaneous and tendon reflex excitability exists. Reflex excitability falls very much below normal after a time. The normal condition of things return but slowly. Relapses of the eruption are followed by changes in the tendon reflex excitability. These observations are of special interest.

Treatment of Gonorrhœa.

Dr. MACFENAU (*Ibid.*), says he has found good results from hydrastis canadensis, twenty grains being given in an ounce of water three or four times a day.

Chordee.

R. Chloral hydrat., $\frac{1}{2}$ drachm; Camphoræ, 12 grains; morph. acetatis, 2 grains; ol. theobroma, q.s.

M. Ft. suppos. no. 6 (15 grains each.)

Sig. One every hour in rectum until relieved.—*Med. & Surg. Reporter.*

Borated Glycerine in Chancroid.

Dr. THIN (*Lancet*), claims to have had excellent results in phagadænic and gangrenous chancroidal ulcerations, from the use of borated glycerine. The ulcers are kept constantly soaked in the glycerine, and soon take on a healthy appearance.—*Chic. Med. Review.*

Syphilitic Infection of the Finger by Medical Men.

Prof. FESSENDEN N. OTIS, M. D., communicates to the *Independent Practitioner* of March particulars of eight cases of syphilis contracted by physicians in making digital examination of of the vaginæ of syphilitic women. The initial lesion of this form of syphilis is described as being uniformly a papule, "coming soon to be of a deep red color, and presenting a superficial abrasion, becoming circular and deeper by a slow molecular necrosis; not by ulceration with formation of pus; the secretion thin and serous, and drying into a scab which is soon displaced by the fluid accumulating underneath." He also remarks "the entire absence of induration; in its place a slight, flat, juicy-looking boggy swelling, or elevation, about like a small peppermint in size and thickness."

As proof of the efficacy of treatment, which was continued in five of the cases for one and a half to two and a half years, he states that subsequently "eight healthy children have been born, and both they and the parents have continued free from any evidence of syphilis."—*Med. & Surg. Jour.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

A New Form of Splint for Fracture of the Patella.

T. CURTIS SMITH (*Med. & Surg. Reporter*):

It is quite needless to inform any surgeon that the maintenance of the widely separated fragments in apposition, in fracture of the patella, is a desideratum devoutly desired. However easily steady apposition of fragments of bones may be attained in other fractures, this is one where the maintenance of apposition long enough to secure osseous union has persistently defied all skill in all time past. Bony union has been, and is now, the exception and not the rule.

The causes of failure are very apparent, *i. e.*, the traction of the quadriceps extensor muscle drawing the upper fragment upward, and that of the ligamentum patella, if not drawing the lower fragment downward, at least does not hold it up to its proper place.

Now, it is easily noted that the insertion of the quadriceps extensor into the patella is by a fleshy tendon as broad as the superior border of the patella, and that that insertion of this muscle is as thick as the bone itself. So that the upper surface of insertion of this muscle is on a plane with the upper surface of the patella, thus leaving no projection or shoulder against which a splint may be braced and permanently fastened, in order to hold the upper fragment down to its place. Again, the layers of fascia and integument, not always thin, which cover the upper border of the patella, add to the difficulty of pushing down the

upper fragment, or of holding it down, very materially.

Again, any considerable pressure by any splint heretofore devised (as far as my limited knowledge goes) has a noted tendency to tilt up the lower margin of the upper fragment, and thus defeat accurate coaptation. The reason for this is plain. Pressure brought on the upper border of the patella must be had by pressing the quadriceps extensor backward at its point of insertion. This necessarily carries the upper border of the bone backward, and therefore tilts the lower edge of the upper fragment forward. The anterior plane of the insertion of the muscle and of the anterior surface of the patella being quite exactly the same, it must necessarily be the case that any considerable pressure at the upper border of the patella must be had at the expense of pressing the tendon backward; but as the insertion is broad, thick and dense, and its reflex contractile response to pressure quite considerable, it becomes at once impossible, or next to impossible, to secure a sufficient projection or shoulder at the superior border, against which to press with a splint in order to bring down and hold down the upper piece of the broken bone.

The ligamentum patellæ below offer very similar reasons for inability to hold the lower fragment up, but not to the same extent as the quadriceps extensor above.

To obviate this difficulty I have devised a splint made to bring pressure to bear on the lateral margins of the bone, where, as will be seen by the shape of the patella, sufficient shoulders may be

found against which to press the splints with as great force as may be needed to bring the fragments together. True, the tendons of the vastus internus and vastus externus muscles extend to those lateral margins to a small extent, but not sufficiently to interfere greatly with the mechanism of this splint. The splints may be made of wood, hard rubber or wire. If of wood, take a pine board one inch thick, three or three and a half inches wide. The lower end should be narrowed to a little over two inches. Now groove out one surface deep enough and broad enough to let the tendon of the quadriceps fall into it. Let the groove become gradually more shallow from the lower end upward. Now make a round notch in the lower end, of just such size as that the sides of this notch will fit on the shoulders or lateral projecting margins of the patella, and at the same time be free from pressing on the upper border where the tendon of the quadriceps extensor is inserted. The whole of the pressure will thus be brought against the comparatively projecting sides of this rather double wedge-shaped bone. And no pressure will be had at the upper edge of the bone to cause tilting of the fragments by pressure on the muscular tendon. The lower splint should be made in just the same way as the upper, only the groove must be deeper and the notch more pointed, to fit the wedge shape of the lower half of the bone. The corners of the board may be rounded off and smoothed up, so as to present a neat and workmanlike appearance, and take away much unneeded bulk and weight.

There should be screws set into the sides of each splint, two inches or more from the ends, one on each side of each splint, and also one on the top of each splint, in the middle, at about the same distance from the margin of each notch,

six in all. To these may be attached elastic rubber straps of sufficient strength to overcome the contractile power of the resisting muscles, and so attached as that they will be tightly stretched when applied. A very moderate continued pressure from these elastic straps will in a few hours overcome all the resisting power of a strong quadriceps muscle, as the muscle will become exhausted and cease to resist the strain brought upon it.

Called to a case of transverse fracture of the patella, how should we apply these splints? First have these splints well and carefully made to fit the patella. Always be sure that the ends of the two splints on each side of the notches do not come quite together when properly applied, and that they fit down on each side of the patella neatly and smoothly. Now secure a long splint for the posterior surface of the limb, reaching from near the gluteal crease to the lower third of the gastrocnemius, or near the heel; pad it well, especially just behind the knee. Also pad the anterior splints above described. Apply the posterior splint and the lower anterior splint, securing them well by a roller. Now tie a strap around the upper end of the long splint and thigh. This steadies the long splint in its whole length. Now bring down the upper fragment of the patella, apply the upper anterior splint and bind it with a roller bandage. If well applied, we believe the edges of the bone will be coapted and retained in place, or will be brought down by the steady pressure of the elastic bands. If now we find the fractured edges of the bone are tilted up, we can put a thin or thick pad, as may be needed, under the anterior elastic strap and bring them down to their proper place. Or a small strip of whalebone may be bent and slipped through the notches into the grooves

after the splint has been applied, and kept there to steady and hold level the fragments.

This splint, by virtue of its reaching well down over the lateral borders, will also be well adapted to the management of other fractures of the patella than those that are simply transverse. In a longitudinal fracture the fragments will be more readily held in apposition by it than would the fragments in the more difficult form above named, and for which this splint was especially devised.

The advantages claimed for this splint are (1) the groove letting the tendon of the quadriceps extensor in, thus relieving the extensor border of the patella from pressure that is sure to tilt the upper fragment; (2) the pressure brought to bear on the free lateral borders of the bone; (3) the reasonable certainty of holding the bone in its place; (4) and last, but not least, the continued tension of the elastic straps that keep up continued tension and persistently resist the contractions of the quadriceps extensor muscle. Also in longitudinal fractures or in stellated fractures its tendency to hold the fragments in apposition, by virtue of the pressure on the lateral borders.

Adhesive Straps United by Buckle and Tongue in Fracture of the Patella.

Dr. E. T. BLACKWELL (*Med. Times*):

The plan of Dorsey, itself a figure of eight with its folds secured to the posterior splint, has been employed with various modifications and many different materials. Agnew's substitution of adhesive straps for the tapes of the latter, with the addition of a key, working in the posterior splint to adjust the force applied, is, perhaps, the best. All the forms of Dorsey fail to apply the power in the line of resistance. The

hooks of Malgaigne are not liable to this objection, but their application to the living tissues is dreaded by both surgeon and patient. Extension of the quadriceps muscle by weights suspended from the surface of the thigh by means of adhesive plaster, and counter-extension by sand-bag to inferior surface of the patella, embody an efficient principle of treatment which can only be carried out in one position, and this is tedious and irksome. The lock-strap is inefficient from the necessity of frequent reapplication to regain the loss occasioned by the slipping of the skin and superficial fasciæ upon the muscles, whereby the extension and counter-extension are diminished.

The apparatus that I have devised obviates this latter difficulty, and those which lie against the other forms; it is easy of application, comparatively painless, makes traction in the line of resistance, and may be tightened daily without disturbing the fragments.

The force is applied as follows: Take two pieces of perforated plaster in rubber combination, long enough to cover the leg and thigh respectively, and about three inches wide. A few inches from the end of each, cut in equally from both edges, so that these will meet when the spread surfaces are turned together. This forms a tongue for one of the strips. To the corresponding one a strong buckle is to be attached by sewing. Fasten one strip to the leg, so that the buckle is opposite the fracture; the other to the thigh, so that the point of the tongue will reach and pass through the buckle and be lightly secured. Strips of plaster may be placed across the extending ones for greater security. The spiral is next applied above and below the knee. A small, rather firm compress is placed beneath the extending and counter-extending bands, so that,

as the tongue is now forcibly drawn through the buckle, the severed portions of bone may be brought together. This has occurred immediately in the cases operated on by me, though, if the gap were wide, it might have to take place gradually. Carded cotton is to be tucked beneath the buckle to prevent chafing. The spiral bandage is now to be continued about the parts in such a way as to co-operate with the force already applied. A splint of some plastic material is now to be moulded to the limb posteriorly, and fastened in the usual way, and the patient's foot so adjusted upon a pillow as to prevent all strain upon the tissues in front of the limb. Daily inspection is necessary, in order that the force exerted be efficient and comfortable. When union is secured, but not firm enough to justify passive motion, the immovable apparatus may be applied, the silicate dressing being perhaps the best. Near the end of the sixth week, possibly sooner, the passive motion may be commenced, the surgeon keeping up firm pressure above the upper fragment by one of his thumbs. A suitable liniment with friction may be used about the stiffened tissues if thought necessary.

Treatment of Fracture of the Femur in Children.

It is well known that SCHEDE was the first who (1877) attempted the treatment of fracture of the femur in children of very young age (one to three years) by vertical extension. Jarnbach (*B. Kl. W.*, 9, '81) condemned this procedure, saying that the permanent position on the back would cause affection of the lungs.

Dr. Herm. Kümmell, of Hamburg, reports now, in the *Berl. Kl. W.*, 4, '82, that he has treated forty such cases, according to the method suggested by

Schede, and he found that children, even badly nourished and under by no means favorable circumstances, had been able to withstand a permanent position on the back for as long as 111 days, without in the least suffering from it, as far as their lungs were concerned.

The *Deutsche Medic. Zeitung* specially mentions, in addition, that the result of this treatment in Kümmell's cases was excellent, as not a single case of dislocation in any direction, nor shortening of the fractured extremity, was observed, and recommends, very properly, the general adoption of Schede's method in all cases of fracture of the femur in very young children.—*Med. & Surg. Reporter*.

Fractured Clavicle.

Dr. W. H. DEWITT gives an account in the Cincinnati *Lancet and Clinic*, August 19th, of a case of a child whose clavicle was fractured, and which united without the knowledge of either the boy or his friends. His mother found the lump formed by the callous and drew attention to it. The bone united perfectly without any deformity. Dame nature, in this case, produced a cure as perfect as the skilled surgeon.—*Chicago Medical Review*.

Bow Legs—New Splint.

Mr. G. R. GILRUTH, (*Braithwaite's Retrospect*): This is an apparatus which consists of a rigid steel rod, fixed above to a thigh-piece made of thin copper shaped to the form of the thigh and attached below to a foot-piece having a box on it to permit the rod to slide in and allow for any increase in the length of the tibia as it becomes straight. Sliding on this rod, so that pressure can be applied at any point, is a tourniquet screw, having a short leather splint attached to it by means of straps and

buckles. This leather splint is placed over the curved portion of the tibia, and when the screw is tightened, can be made to act very powerfully on it. The rod forms the inner splint and also the fulcrum for the screw, and being slightly convex—the concavity being toward the leg to which it is applied—it gives a better leverage and prevents the skin from being pressed on. The splints are applied in the following manner: The foot and thigh pieces are attached to the limb by broad strips of adhesive plaster, then a plaster of paris bandage is applied over the foot-piece and twisted as it is passed over the box, so as to allow the rod to slide freely. The plaster of paris is next applied over the thigh piece. The leather splint, well padded, is then placed over the curved portion of the tibia and secured to the screw by the buckles. The buckles should lie on the leather so as not to press on the skin. Pressure might now be made, but it seems better to wait until the plaster of paris becomes perfectly hard.

The Sub-Luxation of the Fourth Cervical Vertebra.

The patient was sixty-three years old. In a fit of despondency he hanged himself, fastening a rope in his room and jumping out of the window. The fall was eleven or twelve feet. Dr. BARDWELL reports the case in the *British Medical Journal*. Upon examination the patient was almost entirely unconscious, breathing seventeen to twenty per minute, pulse twenty-four. Tracing the cervical vertebræ upward, the fifth was decidedly prominent and then a break with a deep depression. No effort was made at reduction. Only a low pillow was allowed to which the head was fastened by bandages. In a week's time the cervical vertebræ had

nearly resumed their normal position, slowly reduced, it was thought, by the elasticity of the inter-vertebral fibro-cartilage. By the end of the second week the patient was discharged well and with no permanent injury.—*Chic. Med. Review*.

Fat Embolism after Fracture.

From a careful study of the cases, and a review of the literature of fat embolism, Dr. A. MINICH (*Lo Sperimentale*, 1882, No. 3) has been led to consider that the condition is much more frequent than has been supposed. He concludes as follows: 1. In every fracture there is more or less fat embolism, though in children it may be wanting or very insignificant, on account of the small amount of fat contained in their bones. 2. Very seldom is fat embolism by itself the cause of death or alarming symptoms. 3. Non-infectious fat gives rise neither to pyæmia nor inflammation. 4. Death depends principally upon the suspension of function of the nervous centres, which is reduced by ischæmia. 5. The presence of pure or emulsified fat in the urine occurs chiefly in severe and dangerous cases of embolism. It may often appear without grave symptoms. 6. The occurrence of death from fat embolism after fracture must be borne in mind. 7. The therapy is merely, thus far, symptomatic and of very little effect in preventing a fatal result.

Treatment of Burns.

Dr. A. H. BUCKMEISTER, ambulance surgeon, Brooklyn, L. I., furnishes us with the following as the treatment he uses in burns; he says:

"After trying the various dressings for burns in vogue and all of them proving unsatisfactory the following, improvised by the writer, has proved effi-

cacious: To equal parts of linseed oil and water to which lime has been added (making it about three times the strength of the aqua calcis) there is placed enough sodium bicarbonate to make a thick pasty mass (in severe cases morphia may be added); this mass is applied with loose bandages in the usual way. This dressing has all the advantages of the sodium bicarb. alone and does not adhere to the skin. Dr. Brown, House Surgeon to Long Island College Hospital, states that cases brought to him with this dressing gave very good results."

Alcohol In Burns and Scalds.

Saturate a soft piece of fabric with alcohol, lay it over the burn, then cover it with cotton or finely-picked oakum. This is the most cleanly dressing that can be adopted. It may be thought that alcohol applied to a burn will produce more pain; but try it, and you will be agreeably surprised to observe how quickly it will allay the pain; subsequently disturb the dressing as little as possible; wet the dressing occasionally with alcohol, and the result you will find better than by any other method.—*St. Louis Med. and Surg. Journal.*

The Coat Sleeve Method of Performing the Circular Amputation.

Mr. RICHARD DAVY, of Westminster Hospital, describes the above novel operation in a clinical lecture (*Brit. Med. Jour.*), and gives three cases to illustrate its advantages. He dissects back, as in the circular amputation, a sleeve of integument three to six inches in length. Then the soft parts are divided to the bone, and the periosteum carefully peeled off up to the point the bone is to be divided. After trimming off any projecting tendon or nerve from

the stump and tying the vessels, the skin sleeve is tied up with a piece of tape (very much like a bag of flour is closed up), the tape is passed through a cylinder, and the ligatures are allowed to hang through the crucial slit on the face of the stump. The wound may be treated with or without dressings. Mr. Davy prefers none. The surgeon must carefully watch that the tape does not strangle the skin sleeve. Should the stump become œdematous or any necessity for drainage arise, then a drainage tube may be inserted into the face of the stump. According to Mr. Davy, the advantages are: 1. The conservation of an abundance of skin, subcutaneous fat and areolar tissue, which, by mechanical arrangements, are utilized so that the scar is reduced to a minimum and the cushions to a maximum. 2. The total abolition of sutures, which, however necessary, are invariably painful in removal; and the sutures, as previously employed, necessitated a linear cicatrix on the face of the stump. 3. The facility granted to the house surgeon for restraining, and to the patient for escaping, secondary hemorrhage. 4. Freedom from pain, exclusion of air, and adaptability for perfect drainage. 5. The symmetrical appearance and utility of the stump.—*Can. Med. and Surg. Jour.*

Langenbeck's Method of Amputation at the Hip-Joint.

In an interesting letter to the *Medical Record*, the operation is thus described by Dr. HOWELL:

In amputation at the hip-joint he first ligates the femoral artery high up. Then, without transfixing, but using his comparatively short "lappen-messer," he raises an anterior flap, which includes but little muscular tissue, and that only

toward the completion of the section.

After securing all bleeding vessels, he next proceeds to merely outline the posterior flap. This done, he returns to the anterior incision, rapidly deepens this till the joint is reached, disarticulates, and completes the formation of the posterior flap. Two drainage-tubes are used—one in the retiring angle of the wound, which discharges at its inner extremity, while the other passes through the posterior flap and into the acetabulum.

The sutures now being inserted, the wound is dressed à la Lister, except that carbolized charpie, thickly dusted with iodoform, is substituted for the "protective." The wound is redressed after the lapse of twenty-four hours. This iodoform dressing is well nigh universally employed by Von Langenbeck. Indeed, I remember no operation in which it was not used, either in the manner stated or, as in open resection wounds, directly applied to the raw surfaces. Still, I was informed by one of the clinical assistants that toxic effects are rarely met with, and then only in the event of large wounds being regularly dressed with the agent for long periods of time.

Counter Irritation.

Clinical lecture by Dr. A. C. Post (*Med. & Surg. Reporter*). This aged gentleman has for some time been troubled with a deep-seated pain in the upper and fore part of the arm. On a previous occasion I cauterized it at a number of points, which caused so much relief that he desires the cautery reapplied at a part where there is still some pain and tenderness on pressure. The cautery which I used on this occasion is one which you see very exceptionally. It was not originated by myself, but by

Dr. Thorp, who, on seeing me use a small cautery applied at several points, grouped together a number of short wires, and these, heated to a moderately red heat, enables one, instead of making six different burns, to make six burns at one time. If you heat these to a strong heat you make one large scar by burning the intervening portion of integument. But heating it moderately, a number of small scars are made, and for many purposes a cautery used in this manner is preferable to the larger cautery, which is applied by a ball or wedged shaped or conical instrument, as the case may be. A person with a moderate degree of firmness can bear the cautery applied in this manner without taking ether. But where the cautery is to be applied to a number of places, it is rather a severe ordeal to go through with without an anæsthetic. I have had this applied to myself a number of times, and found it a most effectual means of arresting the gangrenous tendency at the seat of a furuncle. I heat this and press on it hard enough to make it go through the skin into the subcutaneous tissue. The amount of irritation following it is very moderate indeed. I think, upon the whole, I like the multiple cautery heated upon the spirit lamp very much more than the Paqueline cautery heated by benzine. For some purposes, however, the latter is to be preferred. You should have the lamp near by, so that the cautery will not cool too greatly while being carried through the air.

Last Saturday I was consulted about a case by one of the attending physicians at the Presbyterian Hospital, the patient having a chronic inflammation over the dorsal surface of the wrist, extending some distance upon the forearm and down upon the hand. There was very great induration and pain. I suggested the use of the actual cautery,

and it was applied in a number of places, carried through the skin into the cellular tissue. There has been a very marked improvement in the condition of the patient. He has suffered much less pain; there is less induration than there was, and the prognosis is much better. I think that in almost all cases of chronic inflammation about joints, especially where the inflammation is attended by a great deal of induration of the surrounding tissues, you will find much benefit from this mode of treatment.

The best means of arresting the burning sensation after the application of the heated wire is a strong solution of bicarbonate of soda. It acts like a charm. It is not necessary to apply it longer than the first day, after which an ointment of a drachm of the extract of stramonium to the ounce of vaseline may be used as a dressing. The narcotic effect of the stramonium will act advantageously in relieving the pain at the seat of the cauterization.

There are many medical men who attach no importance to the use of revulsives or counter-irritants, because they do not know how to explain the manner in which they produce their effect in relieving pain or disease. There are some minds so constituted that they will not admit a fact the reason of which they cannot explain. There are many facts, however, which we have to learn by practical experience and observation, and if we cannot go any further than to ascertain the fact that we can produce relief by a certain remedy, not being able to explain the *modus operandi*, there is no reason why we should not use that remedy. It is desirable we should go further if we can, and explain the *modus operandi*; we do not know the fact, however, that revulsives, whether in the form of sinapisms, or blisters of cantharides, &c., or the actual cau-

tery, do in many instances relieve deep-seated pain and deep-seated morbid processes other than mere pain. The establishment of an irritation upon the surface, immediately above the diseased part, will very often relieve irritations and morbid processes going on at a depth from the surface. There may be a difference of opinion as to the manner in which that effect is produced, but I think you will, in the course of your future experience, find that a very large number of cases are greatly relieved by such remedies. You take one of the simplest cases in which this class of remedies gives relief; a person has a severe pain in the bowels; apply a large mustard plaster over the surface; a burning sensation is produced, and the internal pain, in a large number of cases, is immediately relieved. Of course, if you can get at the seat of the trouble and relieve it by a more radical remedy which aims at the cause of the pain, it is the better mode of treatment. Very often pain in the bowels, depending on imperfect digestion, for instance, is almost instantaneously relieved by the use of powdered charcoal, or powdered charcoal combined with bicarbonate of soda and some aromatic. In that case the pain is relieved by removing the cause, by neutralizing the acid with an alkali, absorbing the gases with charcoal and modifying the sensibility of the part by the aromatic. Very often you will be able to relieve a pain of that kind permanently, avoiding the after ill effects of an anodyne, which relieves the pain by blunting sensation of the parts.

Esmarch on the Treatment of Injuries of the Blood-Vessels in War.

The following is the substance of a paper read before the section of Military Surgery in the International Medical

Congress held in London in August, 1881:

1. The indications for the treatment of injuries to the larger vessels, and for traumatic hemorrhage, have been materially simplified by antiseptics and artificial bloodlessness.

2. Ligature of the trunk of the artery above the wound, formerly practised, is uncertain, and therefore should be abandoned, especially when the tissues are infiltrated by inflammatory exudation.

3. Styptics should also be abandoned, since they are uncertain in their action, and, by rendering the wound dirty, retard its union.

4. In every case of hemorrhage threatening life, the injured vessel must, if possible, be laid bare at the injured spot, and tied above and below with catgut or antiseptic silk.

5. The operation must be conducted strictly antiseptically and, in the case of the extremities, by the aid of artificial bloodlessness (Esmarch's bandage).

6. The chief means of making such operations easy lies in making a long incision, which lengthens the wound in the long axis of the limb. When life is concerned, it matters little whether the incision be an inch or a foot long; as, if it succeed in checking hemorrhage, and thoroughly antiseptically, a long incision heals just as well as a short one.

7. A proper incision having been made through the skin, the deeper tissues are laid open, the left forefinger being used as a director, upon which they are divided to the same extent by a blunt pointed bistoury. They are then held apart by either blunt or pointed hooks.

8. Coagulated blood is now quickly and energetically removed, either with fingers, sponges, or raspatories, and as thoroughly as if it were intended to make an elaborate dissection. The co-

agulated blood covers everything, and is a fertile soil for the noxious matters exciting inflammation.

9. This being accomplished, the vessels and nerves are felt for with the finger, and an endeavor is made to get some idea as to the injury by the aid of the cleansing sponge, with which arteries, veins, and nerves are isolated.

10. If the veins be quite bloodless and collapsed, it is difficult to distinguish them from cords of connective tissue; it is therefore advisable to form a reservoir of blood below the wound by placing a ligature round the hand, for example, before applying the elastic bandage to the arm. Afterward, on elevating the limb and removing the ligature, the blood flows out of the injured vein, if the vessel have been such.

11. If the injured part of artery or vein have been found and exposed sufficiently to enable the whole extent to be seen, the vessel must be isolated and tied, above and below the injury, in a healthy situation, securely and tightly, with catgut or antiseptic silk (reel-knot). The vessel, if not already divided by the injury, is then cut between the ligatures. If any branches be found between the ligatures, they are isolated and tied, and separated from the trunk of the vessel.

12. The tubing is now released, and all remaining vessels from which any blood issues are ligatured; the limb being elevated, as in amputations when the tubing has been removed, to lessen the parenchymatous bleeding.

13. Divided nerves and tendons, should they be found in the wound, are to be united by fine sutures or carbolyzed silk or catgut.

14. Foreign bodies, *e. g.*, bullets, fragments of clothing, very loose bone splinters, should be carefully removed.

15. The whole wound is then disinfected most carefully by washing, rub-

bing and rinsing with solutions of chloride of zinc and carbolic acid, or iodoform spray. An endeavor must be made to penetrate into every crevice of the wound.

16. Counter-openings having been made in suitable situations, and drainage tubes introduced, the wound is closed by antiseptic dressing.

17. The performance of this operation is not suitable to the battle-field, because it requires much calmness, time and care; and because the antiseptic precautions can only be observed in a well-constructed lazaretto.

18. For provisional hæmostasis on the battle-field, elastic compression is alone suitable.

19. The use of styptics is to be forbidden, therefore such articles as perchloride of iron, Pinghwar Yambi, etc., should be left out of the dressing materials.

20. Equally injurious and dangerous are the much used tourniquets, not only because they require a certain amount of anatomical knowledge in their application, but because the pad (be it ever so well adjusted) becomes displaced during transport, and so only checks the venous circulation instead of the arterial; the result being dangerous infiltration if the opening of the wound be closed, and recurrence of hemorrhage if it be open.

21. Satisfactory and lasting compression of the vessels is obtainable by an elastic tube or girth being drawn around the limb several times tightly stretched. By this means the parts are so well drawn together that not a drop of blood can pass through the vessels.

22. No anatomical knowledge is requisite, as the compression is useful wherever undertaken. Displacement of tube or girth is impossible in transport if the ends have been well secured.

23. Tourniquets should therefore be replaced by elastic girths in the stores and in the dressing-bags of the men of the hospital corps.

24. Since caoutchouc suffers by being stored, and loses its elasticity, it is impossible to keep a store of these girths in the magazine; and, in the event of war, contracts would be badly carried out.

25. I have, therefore, given a necessary article of clothing the construction necessary for its double use as a brace and as an elastic tourniquet.

26. This tourniquet-brace consists of an India-rubber girth, 150 centimetres (nearly 2 feet) long, and is strong enough to compress every vessel in a limb at any point.

27. Since every soldier must have a pair of braces, and this one is not dearer than any other, the desire that each soldier should be so equipped in war is a reasonable one.

28. In this case every soldier would carry a means of checking a dangerous hemorrhage, in himself and others, on his own person. In a case of a severe injury he would, in any case, not require braces; and on the field of battle the braces of the dead and wounded could be removed in great numbers if necessary.

29. These braces might also be used for tying-off poisoned wounds, for procuring artificial bloodlessness in operations, and for the resuscitation of the apparently dead after severe losses of blood, etc.

30. It is a matter of course that every wounded man, in whom hemorrhage has been provisionally checked by the girth, should be brought to a lazaretto as soon as possible, in order that the compression may be there removed, and the definite ligature of the bleeding vessel carried out.

31. It is also of importance that, before applying the elastic tourniquet, the limb be bandaged in an elevated position; and, if bones be shattered, that

these should be rendered immovable during transport, by means of splints, etc.—*Lon. Med. Record.*

Extirpation of Half of Lower Jaw for Sarcoma.

DR. OSCAR J. COSKERY, (*Maryland Med. Jour.*)

Peter King, colored, aged 15, was admitted into City Hospital, March 31st, 1882. His family history was good.

size and shape to that it now presents. There is no pain of any amount even after handling.

On April 14th, 1882, the patient was placed in half-sitting position upon the table, and an incision commencing at the mid-line of lower lip was carried



About fifteen months before admission, what the patient called a "gumboil" formed in left side of lower jaw. This was lanced but no matter came. Since that time that whole side of the jaw has gone on steadily increasing in

over largest portion of tumor, first downwards, then outwards, then upwards to a level with lower portion of lobule of ear. The flap was dissected up as usual, the right median incisor tooth drawn, a straight saw used to cut the jaw across

just to the right of symphysis, the soft parts on inner side of jaw separated, and the bone pulled forcibly outwards. The tumor, which principally involved the horizontal and ascending portions, came away entire; but the coronoid process and the neck of the bone were broken across in the rough handling. These parts were taken away afterwards.

In extracting the enlarged gland (marked B in fig.) just back of the jaw, a branch of the external jugular was cut and required ligation. This ligature, with one on the facial, and one upon a branch under the chin, were the only ones required to control the hemorrhage. Hair-lip pins were used to bring the parts together. Quinia and morphia were given internally, and the parts were treated from the first with Listerine—as a local application and as a mouth-wash. On the fifth day the temperature was 104.2°. With this exception the temperature varied from 100° to 102.5° (only once the latter) until on the eighth day of the operation, when it reached the normal. One week after the operation the boy was eating milk and bread, and two weeks after had gotten back to his regular diet—of course chewing slowly. The pins were not taken out until the tenth and eleventh days, and then the wound was found united by first intention along its whole course except where the ligatures were. The boy left hospital on May 6th or twenty-two days after operation. When heard from, six weeks afterwards, the boy was still well.

Microscopic examination by Dr. Keirle showed it probably to belong to the class of *alveolar sarcomas*.

P. S.—I regret that the wood-cut was made from a life-size cast of the boy and not from the patient himself.

A Is the growth as far as the jaw is concerned.

B Glandular enlargement.

DISEASES OF THE EYE AND EAR.

Glaucoma.

According to Dr. E. FUCHS (*Archiv. für Ophthalmologie*), the glaucomatous eye exhibits a peculiar cloudiness of the cornea and loss of lustre, essentially different from the inflammatory opacity, and directly dependent upon increase of pressure. The cornea hitherto clear and brilliant becomes, during an attack of glaucoma, suddenly dim and as if breathed upon by the breath. This cloudiness, always most marked in the centre, disappears around the border without sharp limitation. Reduction of intra-ocular pressure dissipates it in a very short time to leave no trace whatever. As a cause of this appearance, an anatomical examination found an œdema of the corneal parenchyma (dilatation of the nerve canals, and accumulation of fluid under the epithelium.) Under rapidly increasing pressure a larger quantity of fluid is forced into the cornea, dammed up in front of Bowman's membrane, and there very soon produces œdema and cloudiness.—*Chic. Med. Review*.

Diphtheritic Conjunctivitis.

Dr. A. VOSSIUS GIESSEN (*Klinische Monatsblatt für Augenheilkunde*, Nov., 1881), claims good results from the use of a four per cent. glycerine solution of salicylic acid in this disease. A case of diphtheritic conjunctivitis associated with diphtheria of the fauces recovered under its use when aqueous solutions of carbolic, salicylic, and boracic acid had been tried in vain. The salicylated glycerine was painted on the conjunctival surfaces every half hour. There was an immediate reduction of the swelling of the lids and the chemosis, and a large corneal ulcer healed.—*Ibid*.

Perrin on Rheumatic Purulent Conjunctivitis.

M. MAURICE PERRIN, in a paper read at the Académie de Médecine (*Le Journal de Médecine*, 1882, No. 3), has drawn attention to purulent conjunctivitis occurring in connection with acute articular rheumatism, and independent of gonorrhœa. In two of the cases acute rheumatism occurred during the attack of conjunctivitis. — *Birmingham Med. Review*.

Application in Inflamed Conjunctiva.

A correspondent of the *Louisville Medical News*, describing a visit to the Manhattan Eye and Ear Hospital, New York, supplies the formula of a solution in very common use there for inflamed conjunctiva. It is used with an atomizer in the form of spray :

℞. Tannin, grs. x.; soda bicarb., grs. xx.; glycerin, ʒ ij.; aquæ, Oij.

Suppurative Otitis Media following the Plugging of the Posterior Nares.

In an article bearing the above title (*La Tribune Médicale*, March 26, 1882), Dr. GELLÉ first explains the muscular mechanism by which the Eustachian tube is normally maintained in a transient patulous state during deglutition. Dr. Gellé advances a theory that the tube may become permanently permeable to air and fluids. This result depends upon the spasmodic contraction of the dilators of the tube. The muscular spasm may be caused by the irritation of decomposing blood and pus when the latter come in contact with the pharyngeal extremity of the Eustachian tube. This causative condition is present whenever a tampon, applied to control epistaxis, is left in the posterior nares for a long time, and otitis media is the result. Dr. G. refers to two cases

of this kind which have fallen under his observation, and ascribes to Dr. Créquy the honor of first having called attention to the accident under consideration. The author advocates the substitution of hypodermic injections of ergotin for plugging of the posterior nares in epistaxis. — *Med. Record*.

Abscess of Brain from Disease of the Ear.

MR. A. O. HOLBECKE (*British Med. Journal*), before the Midland Medical Society, showed the left hemisphere of the brain of a child aged eight years, exhibiting a large abscess cavity, from which about half a pint of the most offensive pus had escaped. On making the post mortem examination, a small round perforation in the petrous portion of the temporal bone was found, which communicated with the ear on the one hand, and the abscess cavity on the other. The dura mater was healthy. Thirteen weeks before death, the child received a blow on the ear, and complained of much pain at the time. Subsequently her health became impaired and a discharge of pus from the left ear appeared, the pain in the head becoming relieved. Several times the discharge disappeared, the pain in the head being always simultaneously increased. There was no paralysis. Convulsions had occasionally occurred. She was rational, and answered questions intelligently. Twelve hours before death the discharge from the ear ceased, and she at once became comatose and died.

Treatment of Stytes.

As a means of "backing" a styte, Dr. J. P. McGee of Tennessee, states that the practitioner can use to advantage the following treatment :

℞. Fl. ext. belladonnæ, gtt. iij.; aquæ pluv., ʒ ij. M. Sig.—A teaspoonful every hour.

At the same time he may give calcium sulphide, $\frac{1}{8}$ or $\frac{1}{10}$ gr. every hour, for five or six doses, then every three; although the belladonna is often sufficient alone. Remember this is sufficient only in the very early stage of the affection—within the first six or twelve hours. He will find it "back" at least three of the five.—*Med. & Surg. Reporter.*

VENEREAL DISEASES.

Treatment of Gonorrhœa.

Dr. JOSEPH HEANE (*Med. Times*), recommends the following for reducing the amount of gonorrhœal discharges—the prescription, originally, was one of Prof. Pancost's: \mathcal{R} . Aluminis pulv., 3 i.; cubebæ pulv., 3 vii.; myristicæ pulv., 3 ii.; cuinamoin powdr., 3 ii.; M. Ft. Chart. No. xx. These powders may be given several times a day, and in some cases the amount of cubebs may be greatly increased. Whenever the discharge is profuse a few doses of the powders will reduce it.

Circumcision—Death.

Mr. F. H. WEEKES reports the following case in the *Lancet*: A young man, aged seventeen, was admitted to the hospital with double inguinal suppurating buboes. There was also phimosis of an elongated prepuce, apparently due to the presence of three or four soft sores at the junction of skin and mucous membrane. General health good. Circumcision was performed in such a manner as to remove all sore places. This exposed a healthy glans, and a urethra free from inflammation. After the operation the patient was comfortable for four days. The temperature did not rise above 98.5°. The wound healed for the most part by granulation, and there was scarcely any swelling of

the penis. On the morning of the fifth day the temperature was 99.5°, and in the evening the patient was chilly and had a temperature of 105.4°. On the following morning the temperature was 105.4°; pulse 120, weak; respiration 30. He had been delirious during the night. The penis was slightly swollen and covered with a red blush; but this color faded gradually away, and had no definite margin. The posterior lower two-thirds of the left lung were dull on percussion, and in that region could be heard tubular breathing and bronchophony. In the evening temperature was 104.5° although during the afternoon two five-grain doses of quinine had been given. The next morning temperature was 104.5°; pulse 130; respiration 30. He had not been sick, but had taken very little food. There was a dry, brown tongue, and involuntary passage of fæces. During the afternoon the patient became weaker, and died.

Prostatic Obstructions.

Dr. REGINALD HARRISON recently read a paper before the Medical Society of London, in which he advocated the wisdom of early treatment of prostatic obstruction. He believes that at least 33 per cent. of the men who pass 55 years of age, sooner or later, have enlargement of the prostate. He deprecated the idea of waiting until the prostate became so enlarged as to interfere with the passage of urine. He denied the generally taught idea that this gland is so very sensitive, and so resents mechanical interference; it will bear as much manipulation without resultant evil as any part of the body. He uses gum-elastic instruments, two to four inches longer in the stem than usual, with an expanded portion an inch from the tip, which is made to enter the

bladder. Thus the prostatic urethra is subjected to stretching, both upon the introduction and the withdrawal of the instrument. If this dilation is not carried out too rapidly, no irritation will ensue. He closed his remarks by urging, strongly, this early treatment, which when properly and carefully carried out, will do much to prevent subsequent very serious trouble.—*Ibid.*

Permanganate of Potash, in Gonorrhœa.

Prof. ZEISSL, of Vienna, recalling the accidents which may result through the employment of caustic injections in the treatment of gonorrhœa, stated that he had observed in the Vienna Hospital a number of cases of stricture, which he considered due to the employment of too concentrated a solution of permanganate of potash. This method is, it may be said, at the present time, à la mode with the physicians of Vienna.

The good effects obtained from it in the treatment of gonorrhœa cannot be denied, but Prof. Zeissl affirms that the employment of a weak solution is without caustic effect, and yet possesses sufficient astringency to obtain the desired effect. This he has proven in many cases with the following solution:

R. Potass. permanganat., gr. $\frac{1}{2}$; aquæ, $\frac{3}{4}$ ij. M.—*Med. and Surg. Reporter.*

Gonorrhœa.

Dr. D. W. C. WADE, in the *Transactions of the Michigan State Medical Society*, recommends: Take iodoform, pulverised, two drachms; subnitrate of bismuth, two drachms; chloral hydrate, fifteen grains; morphia, five grains; oil of rose geranium, twenty drops; cacao butter, one ounce. Mix, and make twenty-four suppositories $\frac{1}{8}$ of an inch in diameter. Write: One suppository to be pushed into the urethra three times daily.—*Chic. Med. Review.*

Treatment of Stricture by Electrolysis.

Dr. ROBERT NEWMAN in the *Medical Record* for August 12th and 19th, gives an extended account of the treatment of stricture by electrolysis. The mode of procedure is as follows: The bougie is covered with an insulating substance excepting the end, which is to be the negative electrode. The positive electrode is placed on some indifferent spot. The current need not, and should not, be too strong. Six to eight cells are ample. The séance need not exceed ten or fifteen minutes. No force should be used, the bougie being simply applied to the stricture, which will slowly yield to the electric influences. The doctor claims greater permanency from this treatment than from dilatation by a series of steel bougies, with which the connective tissue is only stretched.—*Ibid.*

DISEASES OF THE SKIN.

Treatment of Scars on the Face.

A most important branch of cosmetic surgery is treated by Dr. C. L. BULL, of New York, in a reprint from the *Transactions of the Ophthalmological Society*. He says: "Persistent rubbing and kneading of scars of the face, both those due to burns and those resulting from bone caries, as preparatory to blepharoplasty, have, in a number of instances in the writer's experience, yielded most excellent results. Adhesions of scars, slight or extensive, to the subjacent parts, have been slowly, cautiously and painlessly detached, and a gradual absorption of the firm material in the dense part of the scar has been brought about. So considerable has been the result obtained in some cases that the writer has come to regard this gradual extension and loosening as an important part of the treatment in these cases."

When one reflects on the amount of mental misery these scars often cause, their removal becomes an object of great importance.—*Med. and Surg. Reporter.*

Glycerine to Prevent Scars.

J. B. C. GUZZO finds glycerine most valuable in preventing scars in burns. He uses it diluted with an equal quantity of water or pure, according to the nature of the burn. Or he uses a combination of one part of glycerine with three parts of collodion.—*Gaillard's Med. Journal.*

On the Treatment of Eczema by Diet.

Dr. A. C. RICH writes, in the *British Medical Journal*:

The treatment of eczema by a Banting's diet, as recommended by Mr. Balmanno Squire, is by no means a new departure in the dietetic treatment of skin-disease. The plan has been in use here for several years. The extraordinarily rapid way in which cases of the most chronic kind recover by careful dieting on Banting's principles is very remarkable. The following is an example:

Richard O., aged nine, had suffered from general eczema ever since he was five months old. For this he had been under constant medical treatment, without any permanent good being effected. He came to the hospital on March 6th, where he has since regularly attended as a patient of Mr. Walker. He was ordered the rigid diet. After a fortnight's careful adherence to the diet ordered an appreciable improvement was noted. In a month he was rapidly improving, and now he is almost well. The only other treatment was an ointment of pitch and vaseline.

The best results of Bantingism are no doubt seen in lymphatic infants; but it is also applicable to the chronic eczema,

local or general, of adults. Mr. Squire would apparently restrict the employment of this diet to eczema. As a matter of fact the Banting diet is of great value in other skin-disorders, especially in the chronic skin-affections of stout, free-living patients about fifty years of age.

As to the use of cod-liver oil, I am not disposed to concede that in every case this most valuable medicine and food-stuff must be excluded. In sallow, phlegmatic children, provided the digestive powers be fairly good, I believe the oil, used in small doses, to be of the highest importance. It is well known that cod-liver oil aids digestion where it can be tolerated, and it is usually granted that it acts in this way by aiding the conversion of nitrogenous food. In some children, if all fatty material be forbidden, the digestion ultimately suffers, and the little patient becomes troubled with irregularity of the bowels and also coldness of the feet and hands, with a tendency toward catarrhal affections of the respiratory tract. In these instances a little cod-liver oil, while not supplying too much fat, yet provides enough for purposes of digestion and proper maintenance of the heat of the body. Clinically, it is found that the oil answers best when given after the diet has been rigidly adhered to for at least three weeks or a month; that is, when the system begins to feel the deprivation of fatty materials. The presence of any of the symptoms or signs of lithemia would of course at once negative the use of cod-liver oil.

I have now so frequently noticed improvement in cases of various kinds, not only skin-diseases, by the omission of milk and an excess of saccharine and starchy food from the diet that I venture to think that "Bantingism" is not sufficiently made use of in these days.

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

Cases Showing the Utility of a Laminated Plaster Splint.

Clinical Lecture, by Mr. F. JORDAN, published in *British Medical Journal*:

We have now in the wards, and always have had during the last few years, several cases showing the use of a simple splint—a splint so simple, that I think we may not inaptly call it the universal splint. I will tell you in a few words what it is, and go more into details afterwards. Take a few sheets of muslin, put them one over another, spread plaster-of-paris between them, roll or fold up this “layered” sheet in any convenient form, dip it in water a few moments, lift it out of the water and very gently squeeze it, spread it out neatly and smoothly, and you have a soft sheet of splintage ready for any purpose which splints can secure. This sheet may be little or big; it may envelope a finger, or a limb, or the trunk, or the trunk and the head, or the trunk and the lower limb. It is simply drawn under the part and folded over it. The drawing under, the folding over, and the trimming by means of scissors, are the work of a time measured by seconds. The part is kept in one unaltered position by intelligent force until the sheet sets—a time measured by minutes. A firm, durable and perfectly fitting splint is thus obtained, which may be left on for weeks or months.

Here is a woman who came in with a tucked knee, the result of joint disease of some standing. The knee was flexed

at a right angle, and the head of the tibia was slightly displaced backwards. Under ether, and by a contrivance to which I shall refer again, we straightened the knee. A prepared laminated plaster splint having been dipped in water and unfolded, was drawn under the limb, folded over it, and allowed to set before the extending forces were relaxed. In another ward, we shall see a fractured femur treated by a similar method; the pelvis, thigh and upper part of the leg being enveloped in a layered plaster splint. All our broken thigh-bones are treated in this way, with this signal advantage—we get them up on crutches in a fortnight. Our broken tibiae we get up in a few days. Some of you have recently seen a case of osteitis of the wrist, enveloped in a laminated splint, a hole in which let the thumb pass through. This layered plaster splint is, in principle, the exact opposite of the plaster roller. For the lower limb, especially for the lower limb and pelvis, the unrolling of plaster bandages is a slow and tedious proceeding, and necessitates many movements and many positions. The principle of lamination or stratification in the construction of plastic splintage may, with suitable change of detail, be extended to other materials; but I have hitherto found the checked muslin and thinly spread plaster in superimposed layers the most generally useful—useful in fractures, joint diseases, spinal diseases; useful, in short, wherever rest, immobility and support are needed. The laminated plaster splint is quickly and easily made. The surgeon first determines how much of the limb or trunk it is well to cover. A

pattern is then cut. One of the layers of checked muslin does very well for this purpose, as it is stiff enough to keep its shape, and is easily marked with a pencil. Afterwards, other pieces of muslin are cut of the same size and shape. Six or seven layers make a good average splint; three or four will do for a child; eight or nine may be needed for a heavy, restless or delirious patient. The first layer is laid flat on the table, and sprinkled with a stratum of good dry powdered plaster, which is smoothed over with a spatula or paper knife; on this, with its margins corresponding, is placed the next layer of muslin, which in its turn is sprinkled with plaster. The process is repeated until all the layers are in place. The splint is then slowly and carefully folded or rolled up and kept dry, ready to be dipped in water when wanted. The water—let this be well understood—immediately passes through any number of layers of muslin and plaster, thoroughly drenching them both in less than sixty seconds. The part to be encased is drawn into position, and held so until the plaster partially sets. If the fingers of the extending hand be in the way, as when the foot is included in the splint, a temporary sling of webbing or plaster over the instep and heel may be used, which can be drawn out or relaxed afterwards. A flannel bandage, or layer of wadding or jersey, is next applied without traction. The splint is now dipped in hot water (hot for comfort and for more rapid setting) for a minute or so. When taken out, it is very gently squeezed, being quite sloppy and limp. When the water is pressed out too freely the sheet will be sandy, friable and difficult to apply. The splint is then unfolded, and drawn out in a perfectly smooth and soft sheet; it is next put under the ailing part, and simply folded over. The overlapping

margins instantly and firmly adhere to each other. Traction should be most carefully avoided; perfect neatness is enough. The layered plastered splint is applied with as much ease, as regards limpness and adjustability, as is a fomentation; but it is a fomentation which sets, and, with rock-like firmness, lastingly holds the part in any given position. In the upper limb, the laminated limb sheet should be large enough to overlap two or three inches; in the lower limb, the overlapping should extend to three or four inches; in the trunk, to five or six. A pair of strong, sharp scissors easily trims the splint while it is still wet. Redundance may be now curtailed, or windows made. To get a neat fit opposite joints, especially flexed joints, as the elbow and ankle, the margins of the splint may be notched at each side, or V-shaped bits may be cut out. The corners of a paper box suggests methods of dealing with the elbow. Windows may also be made, and redundancies curtailed very readily, by means of a sharp scalpel, when the plaster is partially set. When the splint is quite dry, a Hey's saw may be used. When it is wished that a sixth or a fourth of a whole limb shall be visible, a longitudinal strip is easily removed with a knife in the early setting stage—a stage which lasts long enough for any desired degree of carving. Windows, scollops or openings of any kind do not weaken a splint; and it is better to make them opposite bony prominences, breasts and other compressed parts, as well as opposite abscesses, wounds and compound fractures. If it be desired, a sheet splint may be put on at first, so as to leave a longitudinal strip uncovered. If so, a separate outer layer of muslin must be large enough to overlap, and be fixed with a row of pins for a few minutes. I have adopted this method several

times ; but I much prefer the overlapping method for ease of application and for efficiency. If, in rare cases, an exposed strip be desired, the carving method in the setting stage is preferable. In the upper limb, a gaping longitudinal splint may be conveniently held in place by a few turns of bandage until the setting is firm. It is convenient, in making a very large splint, to envelope, say, the trunk, or the pelvis and the lower limb, to put it on in two or three pieces made to overlap each other. Where the layered pieces overlap, they amalgamate and form a perfectly homogenous and continuous splint.

I will now describe the method of putting on the laminated splint in a few of its more simple but most useful applications. I begin with a simple method of applying a plaster jacket. It may be put on under the tripod—an advantage when the tripod is needed. I usually adopt the horizontal posture, as advocated by Dr. Walker. Three layered pieces averaging about thirty-six inches by seven or eight inches, are prepared. These three rolls are easily packed, and may be carried any distance. If any suspicion of dampness exists, hold them over a fire a few minutes in a frying-pan lined with a newspaper. Marks having been previously made on the mattress opposite the axilla and the trochanter, the pieces, when taken out of water, are so arranged that the patient, sitting in readiness, lies down upon them. The middle piece is neatly and leisurely folded over the trunk (encased in a jersey) first ; next, the lower and upper pieces are folded over, their margins freely overlapping the central piece. The upper and lower pieces are so applied as to make a waist—the overlapping ends of the upper piece tending upwards, the ends of the lower piece tending downwards. It might be naturally feared that

the margins of the pieces would be sudden or prominent. On the contrary, the margins are graduated ; and, if the water have not been pressed out too freely, the continuity of the splint is so complete that they cannot be found. The armpit and groin portions should be quite freely cut out when the plaster is partially set. The plastered sheet-splint for fractured femur and for hip-disease, is also put on in three pieces, and when applied forms one continuous splint, embracing the pelvis, the thigh, the knee, and the upper part of the leg.

The piece first put on embraces the upper part of the thigh and the pelvis spica-wise, the ends crossing over the trochanter. Overlapping this, and fixing the ends, is the pelvic piece, which in size and position is similar to the lower piece of a spinal jacket. A third large and long piece overwraps the "spica" piece, and covers the thigh, knee, and half the leg. All these pieces are drawn under the patient, and put in place before any one of them is folded over. Moreover, the needed position is also obtained before the folding over begins. The margins of the third piece may need a cut here and there, to avoid wrinkling. The fixity is so complete that, as a rule, it is unnecessary to enclose the ankle and foot. In hip-disease, pulley-extension (put on after the position is improved under ether, if needful), with a splint on the sound side, should restore a good position before the plaster splint is put on. In due time, crutches and a patten on the sound foot may be used. This splint is cheap, durable and simple, and, to my mind, superior to Thomas' splint. Diffused pressure is better than the pressure of stems and bands. Perhaps the greatest utility of the laminated splint is seen in the treatment of knee-disease, especially in that state where chronic and per-

sistent flexion exists. I straighten the tucked knee by a peculiar but simple method. Ether being given, extension is made from the ankle; but, what is much more efficient, direct pressure is made on the knee by means of a long, broad strap of adhesive plaster thrown over the knee, the ends being passed through a hole in the table underneath the knee. As you see, I have here a table full of round holes, each little more than an inch in diameter; but one or two apertures in an ordinary table will do. In keeping up good positions while sheet splints are setting, a peg or two stuck in suitable holes help to steady the extending hands. To return to the knee; when the limb is enveloped in flannel, one assistant takes charge of the ankle, another has the strip of plaster (already fixed on the knee) in his care. A layered plaster splint, of sufficient size to embrace two-thirds of the thigh and two-thirds of the leg, is dipped in water, unfolded and smoothed, and drawn under the limb, the knee of which lies over the opening; a slit is cut with sharp-pointed scissors in the sheet; the adhesive strap is passed through the slit and the hole; the limb is now gently but firmly drawn into position; the knee-strap, with traction made under the table, doing the greater part of the work. The best possible position being obtained, the sheet is lastly folded neatly over the limb, and the position maintained until the plaster is sufficiently set. The assistant in charge of the knee-strap fixes it in a given position by drawing it tightly against the edge of the aperture. This knee-splint should be worn several months, and renewed from time to time until the knee is practically well. A slit in a plaster sheet in no way weakens it, and the principle may be usefully adopted in applying plaster splints elsewhere. In

fracture of the elbow, a band thrown temporarily across the bend of the elbow, and carried through a slit opposite the olecranon, readily keeps the parts in place until the sheet sets.—*Canada Med. & Surg. Journal.*

Recent Fracture of Skull with Depression.

Dr. S. W. GROSS (*Am. Practitioner*): In all recent fractures of the skull with depression, if the latter be moderate, whether simple or compound, the patient should be left alone. If, however, fixed and severe pain at the point of injury, febrile excitement, increase of local temperature and a commencing puffiness of the scalp, supervene within a few days after the accident—signs which are indicative of depression of the internal table and the development of pachymeningitis—elevation of the depression should be promptly effected. In all recent fractures, whether simple or compound, attended with symptoms of compression, the trephine should be resorted to, and the same rule should apply, whether symptoms be present or not, if the depression be considerable and funnel-shaped.

New Method of Reduction in Dislocation of the Humerus.

Mr. JAMES E. KELLY (*Dublin Journal of the Medical Sciences*) recommends the following as successful when other plans have failed: The patient should be placed as close as possible to the edge of the couch, on his back, with his head low. The operator places the injured arm at right angles with the body, and standing against it, with his side to the patient, and his hip pressed firmly but not roughly into the axilla, he folds the arm and hand of the patient, close around his pelvis, and fixes the hand firmly by pressing it against the crest of

his ilium. The second stage, during which the reduction is effected, is very simple, consisting merely of a rotation or version of the surgeon's body with a force and rapidity which necessarily vary with the peculiarity of the dislocation—some yielding most readily to a sudden and most powerful effort, and others to gentle and gradually increasing traction.

—*Chic. Med. Review.*

Arthritis of the Temporo-Maxillary Articulation.

Dr. GOODWILLE, of New York, *Archives of Medicine*, gives the following history and treatment of this affection :

Arthritic inflammation may be of a local or constitutional character. The former may be excited by dislocations, blows, luxations, or any lesions in neighboring parts. In the latter by some blood poison, viz.: syphilis, rheumatism, gout, scrofula, etc., and as such must have disease medicines that are antidotes or specifics to the particular blood poison. It is my desire to call attention to my method of producing *extension* in acute inflammation of this joint from either of the above causes.

A. P. B., of Hanover, N. H., 60 years of age, was brought to me by the late Prof. A. B. Crosby, M. D. He had been a man of very robust constitution, but for the past two or three years had suffered with attacks of gout, and was now certainly an object of pity to look upon.

The gout from which he had suffered came with terrific violence in both temporo-maxillary articulations, and when he came into my office his teeth were chattering, like one in a malarial chill, from excessive irritation and spasm of the muscles of the jaw. This caused great pressure on the inflamed articular surfaces, and gave him excruciating

pain, so that he got no relief except from the effects of morphine, hypodermically administered. The arthritis was preceded by neuralgia of the inferior maxillary nerve. On examination of the mouth, I found that his teeth had no decay in them, but some were very much worn by mastication upon the crowns, and some pulps (nerves) were exposed, and in consequence he had pulpitis, causing neuralgia that was followed by acute arthritis.

In the treatment nothing could be done with him except under the effects of morphine and an anæsthetic. On entering my office, a hypodermic dose of morphine was administered, and when under the effects of the drug, he was given nitrous oxide as an anæsthetic. This relieved him from pain, while consciousness to some extent remained. The pulpitis, the exciting cause of the facial neuralgia, was removed by protecting the exposed dental pulps (nerves) from the air and attrition by means of gutta-percha and an interdental splint. The principle of the treatment of arthritis in these joints is the same as in others, differing only in the method of application. I do not know that any extension appliance has ever been used for the relief of arthritis of this joint.

The method that I employ is as follows : In this case the patient was under the anæsthetic effect of morphine and nitrous oxide. If there is any rigidity of the muscles, cautiously force open the mouth and take an impression of either the upper or lower teeth, and a rubber splint is made from the cast to cover over all the teeth in one jaw. Upon the posterior part of this splint is made a prominence or fulcrum (D), so that when the mouth is closed the most posterior teeth close upon it, while all the anterior teeth are left free. The next step is to take a plaster of Paris

impression of the chin, and from this make a splint (A). On each end of the splint is made a place for fastening elastic straps (B) that pass up on each side of the head to a close-fitting skull-cap. See fig. When the apparatus is in place and the elastic straps tightened so as to lift the chin, then pressure is brought to bear on the fulcrum at the posterior molar tooth, and so by this means extension is made at the joints, and the inflamed surfaces within the joints are relieved from pressure; then immediate relief is experienced.

As soon as this apparatus was put on this patient, his pain stopped instantly,



and he took no morphia. He continued for a time his anti-gout remedies, and after some manipulations of the lame muscles of the jaws under electricity, perfect motion was restored. Three cases similar to the above are given in detail, and the doctor concludes as follows:

1. That arthritis of this joint, like all other joints the result of local or constitutional causes, requires proper and prompt treatment, as it may pass in a very short time from its most incipient stage to one of suppuration and destruction.

2. That arthritis without proper treatment more often results in fibrous ankylosis, and that bony ankylosis is the exception.

3. That the highly developed muscles of the jaw, from pathological changes, the result of inflammation, or even from misuse, have always more or less impaired motion, and in some cases require more treatment than the joint trouble.

4. Cases do sometimes occur in which the poisonous effects of overdoses of mercury have had a disastrous result.—*Canada Lancet*,

Coxalgia.

Clinical lecture by Dr. D. HAYES AGNEW (*Med. Times*):

Here is a little child who has trouble, which we have located in the hips, for the following reasons: I take hold of the thigh, put my finger on the anterior superior spinous process of the ilium, and then carry the thigh in and out in this manner. You see that the pelvis remains quiet. I flex the thigh until its anterior surface touches the abdomen: still the pelvis does not move. Let us now test this on the right side. I take hold of the thigh in the same manner, and you see immediately that the pelvis moves with every motion of the limb. Here, then, is a symptom which is positive, crucial, which settles beyond question that this is disease of the hip, or, in other words, coxalgia. There is another symptom usually present in these cases—that is, obliteration of the fold separating the thigh from the buttock, the gluteo-femoral fold. On the left side there is a distinct crease, but on the right the thigh passes into the buttock without any distinct line of demarcation. You also observe, as the child stands, that the whole limb is ad-

vanced, the foot turned out, and the knee flexed. This is the position of the limb in the first stage of coxalgia.

Coxalgia, as you know, sometimes commences in the acetabulum, sometimes in the head of the femur, and sometimes in the synovial membrane. It usually occurs in early childhood, and in the majority of cases has a constitutional origin. It has been divided into stages: The first stage is characterized by flexion of the thigh, flexion of the leg, and eversion of the foot; following this we have the second stage, in which the posture of the limb is changed, the foot being inverted, and the external portion of the hip being very prominent; in the third stage, disease of the bone, necrosis, and abscess occur.

An important matter is to make the diagnosis as soon as possible. If you will remember the few symptoms which I have given, they will enable you to determine always whether or not the disease is present. Coxalgia is often mistaken for rheumatism.

What is the treatment? The treatment is rest of the joint. A cardinal principle in the treatment of all articular disease is rest. What I mean by rest is absolute immobility of the joint. There are different methods of treating hip-joint disease. There is one plan which consists, as it is alleged, in drawing the articular surfaces of the bone apart, while at the same time the patient is allowed to walk about, the weight of the body being supported on the perineum. This does not secure fixation of the joint, but the supposition is that, the joint-surfaces being drawn asunder, the source of irritation is removed. I take it on myself to say that there are anatomical reasons which make it impossible to draw the articulating surfaces from each other in this way. I

say, further, that no plan that allows the motion of the joint is adapted for the treatment of hip-joint disease. The function of a joint is motion. The more a joint is moved the more blood flows to it; but you do not want any more blood than is necessary for the support and repair of the part. If you have more, you aggravate the inflammation.

The proper plan of treatment is fixation of the joint. The old Physick method, which consisted in the use of a splint, was a good plan; but it was objectionable in that it required the patient to keep the recumbent position. If it is possible by any means to fix the joint and at the same time allow the patient to move about, we have accomplished the great indications in the treatment of coxalgia: the patient is allowed to go out in the air, and the general health is improved. This is an important consideration in all cases of this kind.

The best apparatus for the treatment of this disease is, I think, the one which I here show you. It consists of a large piece of leather, which is fastened around the body. To the back part of this leather is secured a piece of steel. This runs over the buttock, fitting into the gluteo-femoral fold, down the thigh, and terminates halfway between the knee and the foot. Bands of leather extend around the thigh, knee and calf, thus securing the apparatus. Having thus fixed the joint, it is necessary to raise the patient. You may do that either by a shoe like this, with an iron sole, or, which is perhaps more elegant but certainly more expensive, by a shoe with a cork sole, placed on the foot of the sound side, thus raising the patient two and a half or three inches. The patient is then placed on crutches and allowed to go about. This splint is constructed somewhat on the plan of Thomas, a surgeon

of Liverpool, England. It has, I think, been very tardily accepted by surgeons on this side of the water, but it will in time find its way into favor.

You may, perhaps, live at a distance from an instrument-maker, and you want to know how to order this apparatus. Take a piece of flexible metal and apply it to the back of the limb, causing it to fit into all the inequalities. Next take a plaster roller and carry it around the body, commencing below the crest of the ilium and extending upwards to the inferior angle of the scapula. Allow the plaster to remain on for fifteen minutes until it hardens; then slit it up the front and remove it. Send the plaster roller and the metal strip to the instrument-maker, and he can make an apparatus which you can readily apply. If there is any tendency to slip, suspenders over the shoulders will remedy the difficulty.

This apparatus should be kept on for some time. I have frequently had patients who have aborted the disease in eight months or a year. Taking the case in its incipency, you can occasionally bring about resolution of the disease, and prevent it from going through those horrible stages which lead so often to such deformity, and often, indeed, to the death of the patient from the wasting effects of suppuration.

Metastasis of Tumors.

According to the experiments of Dr. WILE, published in the *Medical Times*, the process of metastasis of tumors is now regarded as resting upon an anatomical basis, and the secondary tumors are believed to be the result of the development of tumor-emboli. The question of dispute here is whether the emboli infect the surrounding tissue by a species of metabolism, and thus give rise to secondary tumors, or whether

they grow centrally and produce tumors by virtue of inherent cell-proliferation. Upon this point I would offer the following: In my experiments with tumor particles the particle transplanted never produced any changes in the surrounding tissue indicating any infection, but, on the contrary, it grew independently if it grew at all. In favor of a central growth of the embolus is also the shape of metastatic deposits. It is generally a known fact, among those who investigate this matter closely, that all secondary tumors grow as nodes, and never at the expense of the surrounding tissue. One of the strongest points in favor of an infection or transformation of the surrounding tissue was the observation, that, in cancer around the principal tumor mass in the surrounding connective tissue there existed scattered and isolated cancer nests. These are composed of epithelial cells, and were observed to have no connection with the main tumor. It was, therefore, inferred that a peculiar power of transformation emanated from the primary cancer which transformed the surrounding connective tissue into epithelioid elements. But it has been discovered by Waldeyer and Pagenstecher that the epithelial cells from a freshly-extirpated cancer possess the power of amoeboid motion. This was supposed to explain fully the appearance of the isolated groups of epithelial cells. Yet, these epithelial cancer-nests can be explained in a much more plausible manner, so that the amoeboid motion of the cells is not at all necessary. It is a well-known fact that the proliferation of cancer growths follows the lymph-channels of the connective tissue. The lymph-channels run by no means in a straight direction, but travel in the most circuitous routes. For instance, a channel may start from a primary focus of cell proliferation, de-

scribe a curve, and again reach the level of the primary focus, at the same time the distal end of the curve being some distance from the starting point. Under such circumstances, a section made across the growth in a straight direction shows isolated cancer-foci, which are nothing more than the distal ends of the curving lymph-channels filled with cancer-cells. Of this fact I have convinced myself by an investigation of the mode of growth of my periosteal emboli in the lungs, which presented similar appearances in microscopic sections. I frequently saw isolated centres of ossification which I was unable to explain, until by careful examination of successive sections, I discovered that they were nothing more than transverse sections of extended, curved prolongations from the main or central ossifying embolus.—*Chic. Med. Review.*

Goitre, Cretinism, and Idiocy.

Dr. HERMANN contributes a memoir on this subject (Friedreich's *Blät. für Gerichthl. Med.*, 1882, p. 128), and arrives at the following conclusions: 1. Although poor living, badly ventilated dwellings, improper clothing, etc., may influence the development of these diseases, they cannot actually produce them. 2. There is no connection between the number of marriages between blood-relations, and the number of instances of cretinism. Marriages between blood-relations appear rather to diminish than to increase the tendency already present of producing cretinism. On the other hand, idiocy may be, and appears to be, produced by such marriages; e.g., Howe records seventeen cases of marriages between blood-relations, producing 95 children, of whom 45 were idiots, 12 scrofulous, 1 deaf, and 1 dwarfed. 3. Cretinism is never uniformly manifested

in one locality, but is developed at varying times in certain streets, or houses, and that it becomes active at the time when the human organism is not yet fully developed. 4. The hereditary character of the malady is in certain cases undoubted. 5. In the case of cretinism in the children of healthy parents, there must be a direct specific alteration of the germs by the deleterious matter, without any change occurring in the parents themselves. They are, so to speak, the vehicle for the peccant material. On the other hand, it appears that, when the disease has once appeared in a family, a specific tendency thereto can be traced in the descendants. Even if this tendency have been latent for a time, it often reappears in consequence of some either normal physiological cause, or some newly developed pathological irritation.

DISEASES OF THE EYE AND EAR.

Ophthalmic Aphorisms.

Dr. J. J. CHISOLM, of Baltimore, gives the following valuable aphorisms in a report presented to the Maryland State Medical Society at its last session:

1. APHORISM.—*Do not blister.* In forty-nine applications out of fifty, as I find it used by physicians at large, it is an additional and useless torture to the eye disease from which the patient is already suffering.

2. APHORISM.—*Do not use nitrate of silver.* As constantly prescribed by general practitioners, it is not beneficial in one case out of one hundred, and therefore is a very painful infliction to the ninety-nine who would have been so very much better off without it.

3. APHORISM.—*Do not prescribe sugar of lead.* In every case zinc, tannin or alum is better, and then there is no fear

of having insoluble deposits incorporating themselves with the exposed surface of corneal ulcers.

4. APHORISM.—*Always use weak solutions of the mineral and vegetable astringents in the treatment of eye inflammations which attack the mucous surfaces, and restrict their application to conjunctival diseases exclusively.* One grain of alum, sulphate or chloride of zinc, sulphate of copper or nitrate of silver, in an ounce of water, will, in the majority of cases of conjunctival diseases, do much more good and give much less uneasiness than the very painful five and ten-grain solutions which are so often injuriously prescribed by physicians.

5. APHORISM.—*Solution of the sulphate of atropia, from one to four grains to the ounce of rose water, is an essential eye-drop in the treatment of acute iritis, to break up newly formed adhesions.* One drop of the atropia solution in an inflamed eye is a most valuable means of establishing the diagnosis whether iritic complications exist or not, and should be used in most cases of eye inflammation to find out whether there are any adhesions of the pupil to the lens.

6. APHORISM.—*Eserine in solution of one grain to the ounce of water is the remedy for purely corneal lesions.*

7. APHORISM.—When physicians are in doubt as to the character of an eye disease, they should seek a consultation from specialists who are more familiar with eye diseases than general practitioners can possibly be. Such timely aid often saves the patient a lifetime of trouble.

If physicians would commit to memory and keep at their finger ends, and ready for use, these simple aphorisms, the amount of mental and bodily suffering which they will prevent in their eye patients is beyond calculation. While

all good rules have exceptions, they may safely follow their simple guidance.

Occlusion of External Auditory Meatus.

Three cases of this are reported in the practice of Dr. S. SEXTON, of New York. The first was in a man, æt. 39, who had suffered from occasional otorrhœa and tinnitus aurium, and who fell from a truck and cut his ear and temple. Great swelling ensued and an abscess, which formed in front of the pinna, was opened. Six weeks later he complained of deafness, vertigo, distressing tinnitus and fulness in the ear. The meatus was occluded by a dense integumentary membrane except a minute aperture at upper and back corner just admitting a small probe. Through this a blunt-pointed tenotome was passed and a ring of skin $\frac{1}{4}$ inch in diameter removed. Blood and thick pus escaped, and two days later a wad of cotton-wool. Normal hearing was restored at once. The patient knew nothing of the introduction of any cotton-wool since he was 13, but it was evidently of more recent introduction. The meatus was dilated by a speculum and plugs of cotton-wool, without further symptoms. The second case was in a man, æt. 62, who had been trodden on in boyhood by a horse and his ear severed from the skull. Being replaced it adhered, but not accurately, and the meatus was quite closed by the lower portion of the auricle. A tiny sinus opened in front of the tragus, from which thin matter and wax could be occasionally squeezed. The third case was in a girl, æt. 13, who had a discharge for many weeks from the ear, to prevent her scratching which she was kept lying on it. As a result the raw parts about the margin of the concha adhered. The canal was closed by a diaphragm of skin at the junction of the cartilaginous and osseous portions

Should any signs of middle ear mischief arise, Dr. S. will open the canal without delay.—*Lancet*.—*Maryland Med. Journal*.

Diseases of the Eye Due to Masturbation and Sexual Excesses.

Prof. HERM. COHN observed in cases of masturbation, practised to excess, photopsia, conjunctivitis, blepharospasm, and paresis of accommodation. Photopsia showed itself always as subjective light phenomena in young persons, the eyes of whom presented a perfectly normal pupil, vision and tension, intact sense of space, light and color, clear media, a perfectly healthy optic nerve, and a normal retina. The patients had all kinds of phenomena; they saw spots, stars, light wheels, shining circles, or brilliant dots. In the majority these fata morgana ceased during darkness; in all, on closing the eyes. There were six cases of conjunctivitis. Blepharospasm generally attacked both eyes. Amblyopia has not been demonstrated as a result. Mooren always insists upon the relation between masturbation and paresis of accommodation. Glaucoma and Basedow's disease have been mentioned by Forster and v. Græfe. C. recommends as cure convincing by plain and public talking. Pupils at a certain age should specially be warned against it.—*Bresl. Aerzt. Zeitsch.*, and *Med. and Surg. Reporter*.

Dacryoliths.

Concretions formed by the deposit of the saline elements of the tears, are but rarely observed. Prof. H. G. CORNWELL, of Columbus, Ohio (*American Journal of Medical Sciences*), reports the case of a man, aged forty-six, who complained of an interference with the escape of the tears from the left eye, which

had annoyed him for ten years. An examination revealed lachrymal conjunctivitis, the lachrymal punctum slightly everted, its orifice of normal size and the walls of the canal somewhat thickened. No accumulation of tears in, or any evidence of inflammation of the lachrymal sac. Suspecting a stricture of the canaliculus this passage was slit up by means of a delicate pair of scissors, one blade of the instrument passing readily through the canal without obstruction. On the following day on attempting to separate the edges of the incision to prevent their union, by means of Bowman's probe held vertically, the instrument struck a gritty substance, which proved to be one of four dacryoliths which were arranged bead-like along the floor of the canal. The canal itself, after their removal, was found to be much enlarged as a result of this calcareous deposit.—*South. Med. Record*.

Sympathetic Ophthalmia.

Dr. S. C. AYRES reports three peculiar cases in the *Archives of Ophthalm.* In the first, the affection came on about a year after the enucleation of the originally diseased eye. Examination showing that the stump of the optic nerve was painful, a resection was performed, when all sympathetic trouble disappeared and seven years later had not returned.

In both the other cases, *persistent poulticing* was followed by relief of pain and ultimate recovery.—*Ibid.*

A New Ptosis Operation.

The insufficiency of operations hitherto proposed for the relief of complete or nearly complete ptosis, with little or no power in the levator, is well known. Pagenstecher has devised an operation which depends for its effect on bringing the frontalis to act directly on the upper

lid, and thus substituting the action of this muscle for that of the levator. This is accomplished by producing a superficial vertical cicatrix connecting the frontalis with the edge of the lid. A needle is entered about a finger's breadth above the supraorbital ridge and carried downward beneath the skin to emerge at the level of the lashes; a thread is drawn through and the ends tied together without much dragging. Each day the thread is pulled on till it finally cuts its way out. The reaction is very moderate; the disfigurement caused by the scar is very little, and much more than made up for by the improvement in appearance obtained from relief of the ptosis. Pagenstecher has found one suture suffice in the cases operated on, but suggests that two may sometimes be necessary. For incomplete ptosis a modified form of procedure is advised. A thread armed with two needles is used. One needle is passed under the skin of the lid, parallel to and near the lashes, for the distance of one or two millimeters, drawn through, re-entered at the point of exit, and carried upward beneath the skin to a finger's breadth above the supraorbital ridge. The other needle is then carried from the point where the first needle entered, also upward, to emerge at the same place as the first above the brow. The two ends of the thread are drawn moderately tight and fastened. The loop thus formed may be removed after a longer or shorter time, or allowed to cut itself through, according to the indications of the individual case, and in this way a wholly subcutaneous cicatricial cord is produced. Care should be taken not to sink the needles so deeply above the brow as to wound the periosteum, lest a connection between the skin and periosteum might occur and prevent movement of the vertical cord.—*Archiv. für Augenheilk.; Lond. Pract.*

VENEREAL DISEASES.

The Pyrogallic Acid Treatment of Phagedenæ.

The application of pyrogallic acid to phagedenic chancres is followed by such excellent results that we frequently return to the application used by M. Vidal during his service. There were in the ward two cases in which the phagedenæ had attained considerable size, and two or three applications of the pyrogallic acid sufficed to completely arrest the extension of the lesion. Two days later Vidal practiced auto-inoculation in these cases and the result was negative; he has, in fact, been able to demonstrate that the liquid secreted from the wound after the use of the acid loses completely its virulence. These tests can now be made with impunity, because we have in the pyrogallic acid a means of stopping at once the progress of any injuries that might be produced. The application of the pyrogallic acid gives the wound a blackish color, about which there need be no concern. It should also be mentioned that this treatment induces about the base of the sore a slight induration which greatly resembles that observed in the syphilitic chancre, and might easily lead to error if one were not informed of this result. In cases where the wound was rather large and presented numerous irregularities or cavities, necessarily attended with considerable difficulty in applying the remedy to all its parts, instead of applying the salve he ordinarily used, M. Vidal makes application to its surface of a powder composed of one part of pyrogallic acid to four parts of starch. This application is renewed morning and evening; two successive days of the treatment generally being sufficient to completely modify the phagedenic char-

acter of the wound. The treatment is then continued by means of the sub-carbonate of iron.—*Journal de Med. et de Chirurgie.*—*Med. Record.*

Syphilitic Re-infection of Husband and Wife.

The London *Medical Record* says that Dr. C. Pellizzari, of Florence, reports the following case (*Lo Sperimentale*):

About the middle of December, 1880, a healthy-looking married man, about fifty years of age, consulted Dr. Pellizzari for phimosis, with discharge from beneath the prepuce, and enlarged inguinal glands, which had followed a suspicious intercourse some days before. Induration of the corona subsequently became well-marked, and in due course a macular syphilide appeared, having been preceded by osteocopic pains. The man, on being told that he was suffering from syphilis, remarked that he had suffered from venereal sores ten years before, and had also at that time infected his wife, who, a few months afterwards, during pregnancy, had suffered from general debility, headache, and moist papules of the genital organs. Her child also showed signs of syphilis soon after its birth. Further and positive evidence of the wife's infection was obtained from Professor P. Pellizzari, who had attended her in 1873, for syphilitic perforation of the septum nasi. On February 2, 1881, she was examined by the author, and found to have an indurated sore of the fourchette and enlarged inguinal glands; a month later a maculo-papular syphilide appeared. The two attacks of syphilis in the case of the wife are thus clearly proved; but as regards the husband, the evidence of the former attack appears to rest on the fact stated by the man himself, that he had ten years previously contracted venereal sores after

suspicious intercourse, and on the proof of subsequent syphilis in the wife and child. The husband appears to have suffered so slightly on that occasion, that he did not think it necessary to obtain medical advice. In connection with this it may be mentioned that, in the later attack, when he was under the author's observation, the general symptoms were mild in degree; while the wife suffered severely from recurrent eruptions, nodes, etc., although she had been almost continuously under treatment during the preceding ten years.—*Med. & Surg. Reporter.*

Syphilis and Alcohol.

In a recent memoir published in *la France Médicale*, M. Barthélemy calls attention to the exceptional gravity of syphilitic skin eruptions in patients addicted to the habitual use or abuse of intoxicating liquors. The observations which he gives were all collected while the author was chef de clinique in Fournier's service, and relate exclusively to the waiter girls employed in "brasseries," who receive the name of "inviteuses," because it is their business to have as much liquor ordered as possible. In the pursuit of this métier, they are obliged to drink large quantities of intoxicating liquors; one of them absorbed in one day forty-two glasses of beer, five liqueurs and one "grog Americain;" this, of course, was an exceptional case; but most are continually drinking, in order to incite customers to order for them. When these girls contract syphilis, every symptom, even the primary chancre, is of gravity. In one case the eruption did not disappear from the cutaneous and mucous surfaces for ten years. The chancre in one case spread and became as large as a silver dollar, and was surrounded with an extremely indurated border, and notwithstanding treatment,

the chancre lasted three months. In another case (Obs. III) the chancres were still present when a generalized papulo-hypertrophic eruption appeared over the whole body.

It was remarked also that secondary and tertiary eruptions appeared much more rapidly, were of greater intensity and of longer duration.

The moral is obvious; according to one of themselves, "almost all the 'filles de brasserie' are affected;" and the same is undoubtedly true of the waiter girls in the bar-rooms which disgrace our large cities.—*Med. and Surg. Reporter*.

Immediate Union after Circumcision for Phimosis Complicating Simple Chancre.

M. AUBERT reports (*Lyon Méd.*), six cases in which he obtained primary union after circumcision for phimosis with soft chancres. In two cases there was œdema, and in one, lymphitis, and abscess of the penis. The following is M. Aubert's method of operating: All the surrounding parts are cleansed with carbolic lotion. The penis is then passed through a hole cut in a large sheet of India-rubber sheeting, so that discharge and blood may not collect among the pubic hair, and so become a source of re-inoculation of the wound. The patient is then anæsthetized, and all the sores which are within reach are touched with the thermo-cautery. This having been done, the prepuce is divided at one or more places (several shallow cuts being better than one long one, in order that the incisions may all be included in the subsequent circumcision wound), until it can be fully retracted. The parts are then again washed with carbolic lotion, and all the remaining chancres are cauterized. The operator and his assistants now cleanse their hands, and circumcision is per-

formed with fresh instruments and clean sponges, &c. Lastly, the edges of the wound are united with sutures in the ordinary way. No re-inoculation of the wound occurred in any of the six cases; and the author suggests that, if his method of operating be adopted, circumcision is applicable not only to bad cases, but also to those where phimosis is the only complication.—*Med. Record*.

Venereal and Common Warts.

UNNA (*Boston Medical and Surgical Journal*) recommends for the treatment of condylomata acuminata and ordinary warts the continuous application of unguent hydrarg. containing five per cent. of arsenic. In the case of a young girl upon whose hands were a hundred or more warts, the unbroken application for three weeks of a plaster containing each 0.2 square metre, 10.00 grammes of arsenic and five grammes of mercury, caused entire disappearance of the disease without any irritation of the normal skin. Cure was effected not by reason of necrosis and destruction of the warts, as after the use of caustics, but by resorption, as in cases of spontaneous cure.—*Chic. Med. Review*.

Treatment of Bubo.

The *Revista de Ciencias Medicas* gives the following account of a case of bubo treated according to an Italian method: The chancroid at the end of several days had almost cicatrized, and the bubo presented fluctuation. The patient was placed in a dorsal decubitus, with the extremities semiflexed. The tumor was grasped at its base and pressure exercised. With a straight bistoury of narrow blade a puncture was practised at the highest point. The instrument being withdrawn and the pressure still kept up, the contents of the abscess

were evacuated *ad maximum*. A solution of cupric sulphate (30 ctgrs. to 30 grammes) was then injected in sufficient quantity to cause the abscess to regain its primitive size. After two minutes the liquid was allowed to escape and a graduated compress applied. An inguinal bandage was adjusted to keep up moderate compressure. On the following day there was slight tumefaction, without pain, and the edges of the incision had united. Four days later the small wound had cicatrized without pain or increase of volume. Compression was then suspended and the patient discharged.—*Med. Record*.

Bromide of Potassium Injection for Gonorrhœa.

CHAMBILLIARD: R. Aquæ, ̄ v.; glycerine, 3 ijss.; potassii. bromidi, 3 jss.; laudani, 3 ss. M.

The purpose of this injection is to relieve the distressing nocturnal erections associated with gonorrhœa. The urethra should be injected four times daily, the last injection before retiring. The solution should be permitted to remain in the canal at least one or two minutes, otherwise its effects are unsatisfactory.—*Mich. Med. News*.

DISEASES OF THE SKIN.

Glycerine in Skin Diseases.

M. PIERRE VIGIER finds, from experiments upon himself and upon his pupils, that substances incorporated with glycerine are not absorbed by the skin, therefore he advises as a parasiticide the substitution for blue ointment, which stains the linen and is absorbed, a glycerine thus composed: Corrosive sublimate, 5 grs., glycerine (English or Price's), 100 grs. In spite of the causticity of the bichlo-

ride the skin is not irritated by this mixture, and after extensive applications to the skin no mercury is found in the urine.—*L'Union Médicale—Edin. Jour. Med. Sciences*.

Boracic Acid as an Antiseptic in Skin Diseases.

MESSRS. SAVOY & MOORE'S chemist recommends that boracic acid should be dissolved in glycerine, and this solution incorporated with fatty bases of white wax and almond oil (not vaseline) to produce a soft, homogenous, creamlike compound, free from all the usual sharp-edged, irritating, crystalline plates of boracic acid, which are so hard to reduce to an impalpable powder.—*Practitioner—Archives of Dermatology*.

Gynocardic Acid and Chaulmoogra Oil.

WYNDHAM COTTLE prefers the acid to the oil wherever there is malnutrition, as in gout and rheumatism, late syphilis, &c. He gives half grain dose of the acid with extract of gentian, hops, or conserve of roses several times a day; and has exhibited three grains daily for four months. Locally in eczema the following is a very useful ointment:

R. Acidi gynocard, gr. xv.-xxv.; vaseline, ̄ j.—*Can. Jour. Med. Sciences*.

Ergot in Skin Diseases.

Dr. HEITZMANN, of New York, had found this agent of service in skin diseases of a congestive character. In some cases of pruritus it had acted like a charm. In certain forms of acne, especially pustular acne of the beard, and in erythema, it is very useful. He uses it both internally and locally (the former 3 ss doses fl. ext.)—*Maryland Med. Jour.*

Warts.

Dr. WHITE recommended for warts on the hands: Extract cannabis indica, gr. x.; salicylic acid, gr. xxx.; collodion, $\frac{3}{4}$ i.; to be applied daily for several days. It had not failed once in fifty cases.—*Ibid.*

A Case of Feigned Eruption.

Dr. H. W. STELWAGON reports a case of the kind in the *Archives of Dermatology*. The dearth of published cases of fictitious eruptions would lead one to infer that they are extremely rare. Several have been reported in the past few years. In the case reported, an hysterical female nineteen years of age, there were found a number of elongated crusted patches, some of them parallel on various parts of the body. It was stated that many dispensaries had been visited and much counsel had been had with no benefit. The eruption had mostly been in parallels. The character and behavior of the lesion pointed decidedly to its artificial production. This supposition was strongly confirmed by the existing hysterical condition. The nails were suspected but were so closely bitten off that they were really harmless. After having the case under consideration for several days the confidence of the patient was won, and upon accusing her bluntly of the true nature of her trouble, and assuring her that the fact would not be disclosed, she confessed. The lesions were produced by the constant rubbing of the finger end, by the forefinger and middle finger. But little force was used, and the rubbing slow; but was kept up for an hour or more. She stated that the operation was not painful, but, on the contrary, the sensation was to her an agreeable one. Her object was not so much to create sympathy as to obtain the pleasant sensation the rubbing gave her; besides the

impulse to rub was, at times, almost irresistible. The result was a slight dermatitis, and, in consequence, the crusted lesions described above.—*Chic. Med. Review.*

Leprosy Treated by Eucalyptus.

A case is reported (in the *Lancet* of May 6), by Dr. Stevenson, of Cape Town, of a woman aged 48, suffering with leprosy of about three months' duration, and general in its distribution. Over the arms and legs were a number of tuberculated anæsthetic patches, and the face had the characteristic leonine appearance. Chaulmoogra oil disagreed with the stomach, and tincture of eucalyptus was substituted in half-ounce doses. It produced diaphoresis, and increased the functions of the skin. One year after the disease began, the improvement was permanent. A few faint spots were sometimes seen on her face when heated; these are the sole remnants of the disease. She had also gained in strength and in weight.—*Med. Times.*

Inoculation of Leprosy.

The *British Medical Journal* says that a recent number of Virchow's *Archiv* contains an account by Professor Köbner, of Berlin, of attempts to inoculate leprosy on animals. The results were negative, but the experiments possess interest. They confirmed the investigations already made concerning the bacillus of leprosy. He not only found the organism in fresh juice from the tubercles, but found it in preparations that had been many years in alcohol. While these experiments demonstrate nothing positive further than a corroboration of the causative agent of leprosy, yet they constitute one more step toward the elucidation of the nature of this terrible disease.—*Med. and Surg. Reporter.*

SURGERY.

FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

The Treatment of Pott's Disease Existing in the Upper Dorsal and Cervical Regions.

Dr. A. J. STEELE of St. Louis (*St. Louis Courier of Medicine*.) I would treat a case of caries of the spine, existing below the sixth dorsal vertebra, with the ordinary immovable plaster of Paris jacket, extending from over the hips below to the axillæ above. As the case convalesced I would substitute for the immovable plaster a removable leather jacket.

But did the disease exist in the upper dorsal region—above the seventh dorsal vertebra—the same jacket, extending only to the lower axillary border, would not afford efficient support. For, a line drawn between the two axillæ corresponds to the sixth dorsal vertebra, thus the jacket would not support a lesion of this vertebra, scarcely of the seventh. In such case the jacket must be carried higher, even to the base of the neck, if support would be had from it. This can readily be done by passing the plaster bandage obliquely over the shoulders, the strips crossing each other in the centre between the shoulders both in front and behind. A small triangular space will be left uncovered, at the base of the neck, both behind over the spine and in front over the sternum; this space may be covered either by making reverse turns of the bandage, or by using several thicknesses of triangular-shaped pieces of cheese cloth, saturated with plaster.

By thus carrying the jacket higher, firm support will be obtained for four or five additional vertebræ, as high as the fourth or third dorsal.

It may be objected that thus the whole abdomen and chest would be encased in plaster, and thereby the obstruction to the breathing be intolerable. And this would be true, but to obviate it the jacket must be shortened, limited below to the edge of the ribs, or nearly so, thus leaving the abdomen free for respiration, and the lumbar spine for motion. If the disease is limited to the middle or upper dorsal region there certainly is no need of restraining the lumbar spine.

We would thus have a thoracic jacket; a solid, close-fitting vest, *a la militaire*, tight up to the neck in front.

I have applied this plaster vest nine times, and am pleased with its action and satisfied with the results obtained.

If the spinal disease is above the fourth dorsal vertebra the vest alone is not sufficient, then the additional head rest (as advised by all surgeons when the case is treated by a portable apparatus) must be employed. This, whether consisting of the curved bar and the occipito-mental suspension straps, or of the chin rest, as devised by Taylor and modified by Shaffer, can find the usual attachment to the vest, and thus through it the weight of the head be transmitted to the shoulders. (See Figs. II. and III., taken from life.) This is preferable to employing the ordinary jacket, which confines the abdomen as well as the chest, and transmits the weight of the head indirectly and inefficiently to the hips.

In lieu of plaster of Paris, as a material of which to make the vest, I have for the past two years been using sole-leather, which affords both a portable and removable brace. It is true the plaster vest may be made removable by cutting down in front or at the side

and attaching straps and buckles, but it soon cracks, crumbles and weakens, and thus becomes inefficient. The leather is cleanly, it is firm, light, well-fitting, lasting and convenient. Other material may be used in place of leather, such as felt, or paper (hardened with glue and oxide of zinc or silicate of soda). All of these are shaped over a plaster bust or cast of the patient, as it requires many hours for them to harden, longer than the patient could conveniently remain immovably in one position.

The removable leather vest is made by moderately suspending the patient—self-suspension is preferable—the rope passing over a pulley, one end is attached to the head straps, and the other seized by the patient's hands. This is better than using the axillary stirrups, which draw up or hunch up the shoulders so high as to render the vest ill-fitting when the suspension shall be over. A tight-fitting shirt should previously have been put on the patient, drawn down and fastened between the thighs, one that comes well up to the neck, and preferably with sleeves, even though short. I usually order a male, tight-fitting merino undershirt, remove the buttons and lapels, and sew up the front. After the shirt is on, if it is smeared with lard as far as the bandage will extend, the plaster will not stick on removal; or, on removal of the plaster, the shirt may best be taken off, with the jacket, as though it were a part of it.

The ordinary plaster of Paris bandage is now applied, extending from the base of the neck above to a circumferential line corresponding to the first or second lumbar vertebra below. It may be thinly applied and without stays. So soon as the plaster is well-hardened it is removed by being cut open in the middle line anteriorly and across in front of each shoulder. I slip a strip of tin or

thin steel under the jacket and over the shirt, if it has been greased, under, if not, to cut down upon with a strong knife, that there may be no danger of wounding the patient. The jacket being carefully removed, the cut edges are immediately and evenly brought together, and held by encircling the whole with twine. Thus we have a mould which, being placed upright on a board, and the lower crevices stopped with a little plaster, and the arm-holes stopped by placing over them enameled or rubber cloth, and carrying around the whole a bandage, is filled with plaster of Paris mixed to the consistency of cream; less plaster will be required if a central core is made with a few pieces of brick, empty tin cans or bottles placed within the mould. After a few moments, when the plaster has thoroughly set, the outer casing may be removed, and there will be found an accurate bust or cast of the patient, over which the leather, or whatever other material may be preferred, can be shaped.

As before remarked, I have been using for this purpose sole-leather, as thick as can conveniently be worked, and preferably half-tanned. Raw hide, after being soaked and dried, becomes too hard, and is inclined to curl and warp; full tanned hide is often too soft and flexible, thus the medium, half-tanned, is firmer and yet sufficiently pliable. A pattern, in one piece, either of paper or cloth and somewhat of the following shape—



Fig. 1. Pattern for Leather vest.

is fitted to the bust, and from this the leather is cut, not stinted, generous in

size, which, after being soaked in water for several hours, over night, is adapted to, and firmly bound on the cast. Twenty-four or more hours may elapse before it is *thoroughly* dry; then, and *not until*, it may be removed. The irregular edges may now be trimmed, meanwhile the vest being tried on the patient. A dozen ventilating holes, proper distance apart, are cut into it. A half-inch centre bit, the gauge end having been ground off, is the most convenient instrument for making these holes. The outside surface is enameled with two coats, as tending to strengthen and beautify the vest. The edges are bound with chamois. Hooks, about an inch apart, are attached for lacing—in front of the shoulders and in the median line. The ordinary shoe-hook can be fastened directly to the leather by a little instrument found at the “findings” store. Or straps and buckles may be used; or light leather strips containing either hooks or eyelet holes may be stitched near the edges. Tongues are placed under the joining edges, fastened to the under surface of one side half an inch from the edge, made by wrapping a double fold of stiff wigan with chamois, and stitching it with two or three rows lengthwise on the machine.

A head-rest can be attached by riveting a verticle steel bar* with thin side-arms to the back of the vest. See Fig. II. To this the other parts of the apparatus can be attached by screws.

If in any case the leather should prove too weak and flexible to afford the requisite support, it could be strengthened by riveting to its external surface strips of tin, steel, or brass; but this in my experience has never been necessary.

*In cases demanding it I have used two steel bars passing down on either side of the boss when it has been prominent.

Should it, for any reason, be deemed advisable to change the shape or contour of the vest, different from the body, it could readily be done by adding to or taking from the plaster of Paris cast. For example, to give more space to the boss or knuckle, additional plaster should be added to that prominence, thereby causing a greater hollowing in the leather, thus avoiding undue pressure and the consequent ulceration. This is my usual custom.

I might say here, parenthetically, that I have put in practice this idea in making corsets for lateral curvature. Wish-



FIG. II.

FIG. III.

Fig. II.* Leather vest, with attached horizontal chin rest. I have added an occipital suspending strap to the lateral uprights.

Fig. III. Leather vest, with attached head suspension curved steel bar and occipito-mental straps.

ing to increase pressure on prominent portions of the body, *e.g.*, side of right chest and hip, and to remove it from other opposite portions, I would cut away from the plaster cast in the first

* Taken from a photograph, shows a vest that was worn eighteen months, and yet it is as firm to-day as when first applied. The disease was at the cervico-dorsal junction. It was arrested and the vertebrae consolidated. The general condition improved, and at present the patient is quite well.

instance and add to it in the other, and the corset would likewise be modified.

In some cases it is well each time the vest is reapplied, whether having been removed for the night, or for the purpose of washing the body, that the patient be suspended or be in recumbency. And, speaking of suspension, I like and have adopted the idea of Benj. Lee, of self suspension of the patient several times daily as a part of the treatment. Patients have been injured by too extreme suspension during the application of the plaster jacket. But such suspension need not necessarily be total; the comfort of the patient may be consulted, and the balls of the feet may usually rest on the floor, sustaining somewhat of weight and steadying the body.

In cases requiring the additional head rest or suspension I prefer, for its attachment, the removable vest to the immovable plaster of Paris jacket, in order that the whole apparatus may be taken off at night; for, in recumbency, it is useless, the weight of the head by position being removed from the affected vertebræ. It, of course, should be reapplied in the morning before arising.

There are cases not suited to the portable apparatus; the child not yet walking; a case too ill to be up; a case in which the local trouble is in an acute inflammatory stage. Recumbency is best suited to all these.

In all cases constitutional treatment must not be lost sight of. Fresh air, sunlight, good diet, tonics are essential.

I would further say, though with danger of repetition, that if the disease is in its comparatively early stage and progressing, and in such region that support could be afforded without the head rest, then I should apply the immovable plaster of Paris vest (if in the lower dorsal or lumbar region the jacket). But

if the case was rapidly convalescing, consolidating, I should prefer the removable leather vest or jacket. In all cases needing the additional head-support I should use the leather vest.

Elastic Tension and Articular Motion as Therapeutic Agents in the Treatment of Pott's Disease.

Dr. M. JOSIAH ROBERTS criticises the want of uniformity in the principles of the treatment of Pott's disease as advocated by Sayre. In the lower dorsal and lumbar regions the attempt is made to secure rigid extension and absolute rest of the diseased parts, while in the cervical region the means employed afford elastic extension and a limited degree of motion. From his study of the subject the author concludes that the rational treatment of cervical caries (and incidentally of disease of other portions of the spinal column) is by elastic extension, permitting of limited voluntary articular motion. He claims that by this method the carious vertebræ are relieved of undue pressure, reflex spasm is overcome, and the jar incident to walking or riding is reduced to a minimum. As a consequence of the limited motion, without irritation, allowed to the diseased spine, the flow of blood through the capillaries is facilitated, and the nutrition and repair of the diseased tissues are promoted.—*New York Medical Journal and Obstetrical Review.*

Spina Bifida Cured by Injections of Iodine.

Mr. A. PEARCE GOULD reported the following case to the Clinical Society of London (*British Medical Journal*): A boy, aged six months, was brought into the hospital, with a tumor over the lumbar vertebra about the size and shape of a large tomato. It was translucent,

fluctuating, sessile, covered with healthy skin. The child was otherwise perfectly healthy. The tumor became tense when the child cried, and pressure on it caused fullness of the anterior fontanelle. One ounce of fluid was drawn off, and one drachm of Morton's iodoglycerine solution injected. This producing no effect the operation was repeated a week later, when half a drachm of the same solution was injected. After this the tumor became solid and shrank. The fluid removed was analyzed, and found not to contain even a trace of sugar, showing that it was arachnoid and not cerebro-spinal fluid. During the discussion that followed, it seemed to be the sense of the Society that while this was the best treatment known at present for spina bifida, the successful cases were very few and far between. The President, in conclusion, stated that he believed that Dr. Morton now thought it advisable not to draw off the fluid from the spina bifida, but merely to inject the fluid, that being quite sufficient for the treatment of the case.—*Med. and Surg. Reporter.*

The Early Diagnosis of Spinal Caries.

Dr. WILLIAM RUSSELL sets great diagnostic value upon the production of pain by pressure on the shoulders, in case of incipient spinal caries. He states that he has never failed in eliciting pain when he suspected caries. The pressure should not be downwards only, but also downwards and laterally, so as to explore in this way both sides of the vertebral column. The absence of pain over the spinous processes is of little value, and is frequently noted where caries really exists. If the lumbar vertebræ be affected, "pain in the stomach" is frequently complained of, and pain can be produced by pressure through the abdomen. Pain in lumbar caries

can be brought on by a full meal. Pain in stooping is also an early and valuable diagnostic sign.—*Brit. Med. Jour.*

Wire Ligatures for Divided Bones.

Dr. T. SYMPSON records two cases in the *British Medical Journal*, wherein he obtained excellent results in approximating divided bones with wire ligatures. The first case was a crushed foot; he amputated according to Pirogoff, and fastened the os calcis to the tibia by iron wires. The operation wound was completely healed in ten days, but the wires were left in six weeks. The second case was a resection of the knee joint. The femur and tibia were brought firmly together by two iron wires, one on the outer, the other on the inner aspect; a most complete union was obtained. The operations were performed under antiseptic precautions, and the wire caused no irritation. It is desirable that the apertures made by the drill should be at least a quarter of an inch from the sawn surfaces, and that these surfaces should be very accurately approximated by twisting together the ends of the wires; not more than twice, however, otherwise difficulty will be experienced in removing them. Iron wire, such as that used for the stilets of elastic gum catheters, in size about No. 22 of the gauge, will be usually found the best.

Cazin on the Diagnosis of Hip-Disease by Rectal Examination.

Dr. H. CAZIN (*Rev. de Chir.*), refers to the difficulty of diagnosing the exact seat of the disease, especially with regard to the acetabulum. This difficulty is of much importance when the question of resection has to be considered, and is one of the strongest points of argument advanced by the opponents of

resection. The author made researches in 98 cases of hip-joint disease, 64 being suppurative and 34 non-suppurative. Hitherto, only incomplete evidence has been obtained by depending upon the seat of the pain, the seat of abscesses and fistulæ, and by exploration with the sound.

Abdominal palpation enables us to detect enlarged iliac glands or pelvic abscesses; but if we also examine the patient through the rectum, the diagnosis will be much more sure. The hip-joint, from its deep position in the tissues, is not very accessible to ordinary methods of examination, but the finger can approach it most easily through the rectum. In the cavity of the pelvis, immediately above and a little behind the obturator foramen, is a quadrilateral surface of the bone, corresponding with the bottom of the acetabulum. In a child under fourteen years of age, this part of the pelvis is partly cartilaginous. The Y-shaped cartilage is so situated that the area of the base of the acetabulum is divided by a transverse line of cartilage into two equal parts, and the lower half is again divided by the horizontal line of cartilage.

In examining a patient, the natural extent of the cartilage should be considered, and the two sides should always be explored for the sake of comparison. This mode of examination has afforded appreciable results in 49 of the 98 cases which Dr. Cazin has had under observation. Of the 64 cases of suppurative hip-joint disease, positive results were obtained in 37. Of the 34 non-suppurative cases, in 12 only was the examination *per rectum* diagnostic. The ages of the patients were between three and eighteen years, and the majority were between eight and ten years; 41 were boys, and 23 girls. Examination *per rectum* disclosed an alteration in the pel-

vis in 36 of the cases. Sex has no importance with regard to the facility of examination. Among the elder girls, the presence of the uterus has caused very slight trouble, and the position 'on the knees' has facilitated the examination. In young adult females, recourse should be had at the same time, or exclusively, to examination *per vaginam*.

The results of Dr. Cazin's examinations have been verified six times by resection, four times by necropsy and twice by resection and necropsy combined.

The symptoms elucidated by a rectal examination have been pain localised to the postcotyloid surface, produced by pressure; enlargement of the intrapelvic glands; thickening of the bone; depression, flexibility, mobility, destruction, or perforation of the postcotyloidean surface; congestion of the soft parts; and pelvic abscess.

Pain upon pressure is the least certain of these symptoms. If the bone be penetrated, and the head of the femur be felt by the finger, a doubt in diagnosis may be removed if upon movement of the thigh the head of the femur is felt by the finger (*per rectum*) to move. Many cases are recorded. One was the case of a girl, thirteen years old, in whom there were some symptoms of hip-joint disease, but it was thought by one of Dr. Cazin's colleagues that contraction of the muscles was the only affection. Under chloroform the deformity disappeared, and the joint became freely movable; and it was only by a rectal examination, which disclosed a postcotyloidean swelling; that Dr. Cazin was convinced that articular disease existed. In conclusion, Dr. Cazin urges the adoption of this means of diagnosis, in addition to other methods, especially in reference to the subject of excision of the joint. He also maintains that re-

dressement forcé should never be attempted until an examination *per rectum* has been made.—*London Med. Record*.

Elastic Ligature in Abominal Surgery.

The Cincinnati *Lancet and Clinic* quoting from the *London Medical Record*, says: "An important communication on a new method of operation has just been made on the gynecological clinic of Prof. HEGAR, in Freiburg. It would seem that a means has been found by which total extirpation of the organs of the abdomen, e. g., the spleen, kidneys, and, perhaps, even of the liver, can be undertaken without very much danger. Hegar was led to use the elastic ligature in the treatment of intraperitoneal fibroid pedicles, by the very favorable results he previously achieved in thus treating extraperitoneal fibroids, the danger of hemorrhage from the pedicle being by this means entirely excluded. Kasprzrk, his assistant, in a communication to the *Berl. Clin. Woch.*, No. 22, 1872, has published the results of the experiments upon animals, which consisted in placing pieces of elastic tubing, previously disinfected, in the peritoneal cavity of a rabbit, and killing the animal five weeks later, when it was found that the elastic had become fastened to coils of small intestine by fibrous tissue, but not a trace of suppuration was visible. A repetition of the experiment gave the same result. The omentum, uterus, spleen, liver, and kidneys, have been ligated partly with elastic tubing, partly with solid India-rubber ligatures, the stumps either being cut off or burnt with the thermic cautery. The operation was successful with the omentum and uterus, but not as yet with the liver and kidneys. Kaltenbach, at the advice of Hegar, sank the pedicle of a fibroid secured with an elastic ligature,

into the peritoneal cavity after all the most carefully applied sutures had failed to control the hemorrhage. Twelve days after the operation the patient was doing well. Care, of course, would be needed to prevent the ligatures from slipping. Hegar has devised an instrument for this purpose.—*Chic. Med. Review*.

Treatment of Malignant Pustule.

A shepherd, suffering from malignant pustule of the face, was treated in the ordinary way, without checking the progress of the disease. Tincture of iodine was then given internally, antiseptic washes being continued. Hypodermic injections of a two-per-cent. solution of tincture of iodine were also administered around the zone of inflammation, and subsequently into the oedematous region. The next day the delirium, as well as the sweats and chills, had disappeared, and the pulse was stronger. An inflammatory circle was visible around the eschar. A continuance of the treatment resulted in a complete cure.—*La Revista de Méd. y Cirugía Pract.*—*The Practitioner*.

On the Local Treatment of Carbuncle by the Moist-Sponge Dressing and Counter-Irritation.

Dr. GEORGE McCLELLAN (*Medical Record*): Carbuncle is always a formidable disease. Even in successful cases the system is generally kept weak and depressed, owing to the severe drain it has borne, and the protracted treatment by the ordinary methods in use. The general treatment must be adapted to the circumstances of individual cases, but for the purpose of arresting the local inflammation and removing the slough, which is characteristic of the disease, various methods have been pursued.

Heat and moisture, by softening the tissues, hastens suppuration and relieves tension and pain. The *sponge dressing* is admirably suited for furnishing these conditions; and as I have employed it with the result of speedily removing the disorganized tissues and subduing the carbunculous inflammation in a remarkably short period of time in many very grave cases, I feel justified in calling attention to its use.

A soft sponge, large enough to embrace the entire surface of a carbuncle, should be applied by a bandage firm enough to exert gentle and uniform pressure directly upon the inflamed part. Small slits or openings should be cut in the bandage, so as to readily admit of a warm liquid being poured into the sponge from time to time. The peculiar suction power of the sponge, which the moist state augments, rapidly removes the suppuration as it occurs. The pressure prevents undue infiltration and relieves the tension, and consequently the pain, which is often a most distressing feature of the affection. The compressibility and elasticity of sponge admits of the nicest adjustment, so that any desired degree of pressure may be exercised. This is important in cases where the carbuncle has not yet developed the characteristic slough, for very often the determination may be aborted by uniform pressure. The dressing should be removed, when suppuration is established, twice a day, and the sponge thoroughly washed out and re-applied.

At each change the sponge will be found to contain all the discharges, so that the condition of the parts can be clearly seen. Generally the slough will detach itself within a few days, and be found adherent to the sponge upon its removal, leaving a free granulating ulcer in its place.

The tendency to spread, which many carbuncles manifest at certain stages, is due to the intensity of the inflammation and the profuse infiltration into the tissues, which destroys the barrier of lymph. Nature ordinarily throws out to check the progress of the disease. In order to prevent this I have been in the habit of applying a solution of nitrate of silver or iodine liniment, in a circle around the carbuncle, as a counter-irritant. I will instance one case out of many. An old woman, over eighty years of age, was admitted into my ward at the Philadelphia Hospital with a carbuncle the size of a saucer on the back of her neck. She was greatly enfeebled and suffering severely. The tissues were indurated, angry and livid. There was no discharge, although the surface was cribriform, having many openings through which the slough was visible.

A zone of iodine paint was applied about the swelling, and a large, soft, moist sponge applied with a four-tailed sling. Openings were made so as to keep the sponge moist with warm carbolic lotion (1-30), and a small shot-bag adjusted so as to exert considerable pressure. Within an hour the pain was relieved, and the next day the slough was loosened, the tension being entirely removed. In a fortnight the patient was discharged cured, with a cicatrized surface, showing no perceptible loss of structure. In view of the advanced age of the patient and the extent of the carbunculous inflammation, the result was certainly remarkable.

The usual method of employing poultices to remove the slough is tedious and disagreeable (unless they are very frequently changed), and does not admit so readily of exerting pressure, which, as I have attempted to show, exercises so beneficial an effect in preventing infiltration and overcoming ten-

sion. The old-fashioned practice of making a crucial incision as a preliminary step in the treatment of carbuncle has been in a great measure abandoned, except on the face or lip, as it neither hastens the cure nor lessens the suffering.

The quality of drainage which a sponge possesses comes into value in the treatment of carbuncle, as it has been found to do in all the forms of dressing to which it has been applied.

VENEREAL DISEASES.

Excision of Chancre as a Means of Aborting Syphilis.

Dr. P. A. MORROW read a paper on the above subject before the N. Y. Academy of Medicine (*Med. Record*), in which the question was asked, Is it possible by excision of the initial lesion to destroy the syphilitic virus and so prevent infection of the general system? The author of the paper then presented the theories and practice of Bèll, Hunter, and Ricord concerning the treatment of chancre, and stated that it had been an almost universal practice until a comparatively recent date to destroy the primary sore with caustics as soon as it was recognized.

Dr. Morrow then gave a *résumé* of the claims of the partisans of excision, and described the manner of performing the operation. The method consists in lifting the indurated mass, and, with a knife, making a clean incision through the healthy tissue immediately surrounding it. The loss of tissue was rarely followed by unfavorable results, such as cicatrix, deformity, etc. Subsequent induration in the cicatrix might require a secondary excision. The claims for the method had been that it prevented the development of syphilis, or that the

virus was attenuated by the procedure, and even if its abortive effects were negative, it was to be recommended as a local adjuvant, thereby converting what might prove to be a troublesome ulcer, into a sore which frequently healed by first intention. Secondary adenitis had not been regarded as a contra-indication to excision, and when performed in time the claim had been that it prevented the appearance of the secondary symptoms of the disease.

Of course, if the local lesion be evidence of a constitutional affection, it was impossible to arrest or modify the effect of the general disorder by excision or other methods of treating it.

The author of the paper then presented an outline of the ordinary evolution of syphilis. The first appreciable phenomenon was always manifested at the point of infection, and after the lapse of a certain period of time an eruption of secondary symptoms took place, etc. Here the question arose, At what particular time does the generalization of the virus occur? And the views entertained concerning the nature of the chancre were given; that is, whether it was a purely local lesion or the manifestation of a general disease. The conclusion reached was that the teachings of analogy and the deductions from experiments were opposed to the theory that the chancre is a purely local affection.

Turning to the clinical aspect of the question, reference was again made to the views and practice of Bell, Hunter and Ricord, and the teachings generally in the French and German schools. Under this head were studied inoculation experiments which had been performed, and also some of the sources of error, in forming an estimate of the value of excision, were pointed out, such as the fact that all syphilographers recognized

the impossibility of determining positively the exact nature of a suspicious sore until induration had developed, and also that medical literature was full of cases in which the most energetic treatment practised early had failed to prevent or retard constitutional symptoms.

Dr. Morrow believed it to be the opinion of most syphilographers that destructive cauterization of the primary lesion was absolutely useless as an abortive measure. Even Ricord had been converted to the belief that cauterization or excision was inert as a prophylactic measure.

With reference to excision and its results, he had collected the records of 222 cases, of which 60 had been reported as successes; by success meaning the non-appearance of secondary manifestations of syphilis within a period varying in length from four months to four years.

Criticisms upon the report of the sixty successful cases were then made. A certain number had been reported by unicists, and were open to the objection that the sore excised was not chancre, the initial lesion of syphilis. Some cases, also, had been reported as successes where the operation had been performed before the time had arrived at which it was possible to determine exactly the character of the lesion.

The conclusions reached by the author of the paper were substantially as follows:

1st. That the facts of clinical experience, as well as the deductions from analogy and experiments, were opposed to the theory of the local nature of chancre upon which the practice of excision was based.

2d. That the practice of excision of chancre as a means of aborting syphilis was condemned by the results of clinical observation.

3d. That the sources of error in recorded successes were comprehended under doubtful diagnosis and insufficient observation.

4th. That in cases where secondary accidents failed to appear after excision there was no positive evidence that the result was due to an abortive influence of the operation.

5th. That there was no evidence that excision of chancre attenuated the syphilitic virus or modified the general symptoms of the disease.

6th. That it could not be recommended as a local adjuvant, because it was opposed to the principles of sound conservative surgery.

Phagedænic Chancroid—Hemorrhage from the Penis—Retention of Urine—Aspiration of the Bladder.

Dr. C. S. BRIGGS (*Nashville Jour. of Med. and Surg.*): Charles G., white, æt. 26, admitted into the Medical College Hospital in July, suffering with a profuse hemorrhage from the penis. Several weeks before his admission he had, after intercourse, discovered a chancroid just alongside the frænum, for which he had been treated by a physician. Phimosis had occurred and direct applications to the ulcers interfered with by this complication. Inflammation and swelling, with great pain, rapidly supervened. The discharge of pus from the preputial orifice was very profuse. The day before his entrance into the hospital, hemorrhage from the penis had commenced, and had continued steadily until, when he came to the hospital, he was completely exsanguine and exhausted. I was called to him at night, and found the penis very much enlarged and hemorrhage taking place in drops from the mass of enlargement constituting the end of the penis. Great fetor was present. Percussion revealed

the fact that the bladder was greatly distended with urine, and upon interrogation the patient informed us that he had not passed urine for thirty-six hours. I endeavored to introduce a catheter, but failed to find the entrance to the urethra in the disorganized mass. As the symptoms were pressing, the bladder was aspirated above the pubes and over a quart of urine evacuated. The mass of sloughing tissues, together with clotted blood, was removed after considerable difficulty, partly with a stream of carbolized warm water, and partly by the scissors, and the extent of disease revealed. The entire upper portion of the prepuce was destroyed, only a small strip of the under portion of that appendage being left. About four-fifths of the glans penis had been included in the phagedænic process, together with a portion of the upper part of the corpora cavernosa. The urethra was exposed for about an inch and a quarter, only the floor of that canal remaining. After the surface of the extensive ulcer had been thoroughly cleansed with carbolized water, iodoform was thickly dusted over it, and a layer of absorbent used to absorb the discharges. The bladder had to be evacuated by a catheter for several days. Morphia was required to allay pain. Tartrate of iron and potash in 20 gr. doses was exhibited regularly. Under this treatment the patient improved rapidly, and the disease was soon limited. As soon as complete cicatrization shall have been accomplished, a plastic operation will be required to give some shape to the organ.

The Positive Treatment of Gonorrhœa.

A. M. R. C. S. correspondent of the London *Lancet*, gives the following treatment for gonorrhœa: "I get one pound of roughly-ground cubebs (I

grind my own, and so can rely upon its freshness); this I put into a 200 oz. or wide mouth bottle of commerce; to this I add 2 oz. of the iodide of potash, filling up my bottle with cold water, into the mouth of which I drop several large lumps of camphor, simply to make it keep. This I shake up two or three times a day for a few days, of course keeping it in a very cool place, afterwards pouring off the clear infusion, which I administer to my patients in regular consecutive doses.

Use of Condom in Gonorrhœa.

Dr. C. H. CHALKLEY, (*Southern Clinic*): Several years since, one of my patients, suffering with gonorrhœa, complained to me of the annoyance caused by the rags, etc., worn around the glands penis to keep his clothing free from the discharge. He asked me if I could not recommend some other mode of cleanliness that would not be open to the objections that accompany the tying of rags around the part. The idea of using a condom immediately suggested itself to me, and I advised its use. At his next visit he expressed himself as being very much pleased with the treatment. Since that time I frequently prescribed the same thing for other patients, much to their satisfaction. My plan is to cover the glands with a thin layer of disinfectant cotton, and then draw the condom over it. By this means undue pressure is avoided, perfect cleanliness obtained, and the movements of the limbs are not interfered with, as would be the case with a cumbersome bandage.

Treatment of Gonorrhœal Orchitis by Position and Laudanum Embrocations.

Dr. ROCHA (*Riv. Ital. di Ter. e Igie.*) has obtained very happy results in the treatment of gonorrhœal orchitis. He

places his patients in the dorsal or lateral decubitus, and elevates the testicles gently by a pad which adapts itself to the movement of the patient. Every two hours he applies to the affected member an embrocation containing five to eight drops of Sydenham's laudanum. Under this treatment, orchitis, which has begun with the greatest intensity and acuity, disappears in eight, and sometimes in four days. In the subacute and chronic forms, in which there is no pain, laudanum invariably produces favorable results with safety and speed. Testicular induration, ordinarily of slow resolution, has been observed to disappear entirely under the influence of laudanum in fifteen days. Thirty cases have been cured in this way without general symptoms, due to absorption of the drug. A slight somnolence, easily yielding to coffee alone, was observed. Although Dr. Rocha does not pretend to explain the therapeutics of laudanum in orchitis, he thinks its action is altogether local. Alimentation is to be regulated according to the degree of the fever.—*La Cronica Med.—Medical Record.*

DISEASES OF THE SKIN.

Treatment of Eczema of the Genitalia, Pruritus and Leucorrhœa.

In cases of eczema, in which glyceroles and unguents have failed, the following formula has been successful:

℞. Chlorate of potassium, 30 grammes; wine of opium, 50 grammes; pure water, 1 quart.

Applied to the parts by linen compresses covered with oil silk. If there is much inflammation, precede this with warm hip baths and cataplasms sprinkled with powdered carbonate of lime. In obstinate pruritus, associated with leu-

corrhœa, a tablespoonful of mixture of equal parts of tincture of iodine and iodide of potassium, in a quart of warm tar water (tar water holding the iodine in solution) used daily, night and morning, removes the pruritus and ameliorates the leucorrhœa. In fetid leucorrhœa two or three tablespoonfuls (in a quart of warm water morning and evening, as an injection) of the following formula will be found useful:

℞. Chlorate of potassium, 12 grammes; wine of opium, 10 grammes; tar water, 300 grammes.

Or, ℞. White vinegar (or wine), 300 grammes; tinct. eucalyptus, 45 grammes; acid salicylic, 1 gramme; salicylate of soda, 20 grammes.

One to five teaspoonfuls in a quart of warm water as an injection two or three times a day.—*Review of Gynecology.—Obstetric Gazette.*

Treatment of Eczema.

Dr. LASSAR attaches great importance to the use of antiseptics. He recommends that the parts affected should be at first well soaked with antiseptic oil, of which a considerable amount is absorbed by the skin. A muslin bandage soaked in oil is then applied and covered with oil-silk. The oil may be rendered antiseptic by the addition of one to two per cent. of carbolic acid, or of salicylic acid or one and a half per cent. of thymol. Sometimes the carbolic acid can be borne only for a short time, as it will of itself produce eczema. The thymolized oil is especially useful in pemphigus and erysipelas, and it has been used in burns. Rape-seed oil may be used in place of the more expensive olive oil, but drying oils, such as linseed oil, are to be avoided, as they may cause inflammation. In chronic eczema, especially in infants, and in

eczema of the face, he recommends an ointment. The formula for an ointment in eczema of the face, which cannot be rubbed off during sleep, is:

Salicylic acid, 3 ss, 2.00 gm.; oxide of zinc and starch, ʒi ʒ vjss; 25.00 gm.; vaseline, 3 xiiij; 50.00 gm.—*Annales de Dermatol.—Lond. Pract.*

Eczema of the Anus.

Dr. J. ASHWORTH, New Point, Missouri (*Medical Brief*), claims to have had good results in eczema of the anus from a combination of juglans cinerea and Fowler's solution.

Inoculation in the Treatment of Pannus.

The heroic measure of inoculating gonorrhœal pus for the relief of severe pannus, says the *Medical Record*, has been tried in three cases in the Ophthalmic Division of Charity Hospital, with the following results: First patient totally blind in both eyes for several years, was inoculated with gonorrhœal pus. He was discharged with vision 10-200, 2-200. Second patient, right eye with white leukoma and partial pannus; vision 6-100, 12-100. Third patient, vision 20-100 in right eye, in left eye perforated cornea, and perception of a moving object at a distance of two feet. Second and third patients had perception of light in one eye, while with the other each patient could count fingers at the distance of a foot. Both were inoculated with a traumatic urethral discharge, which ceased after a ten days' treatment. The results were so good as to merit further trial, although the procedure is confessedly severe. *Chic. Med. Review.*

The Eradication of Nævi.

Dr. BROWNING publishes in the Australian Medical Gazette, his treatment of Nævi by electrolysis. A large posi-

tive electrode should be used and the negative electrode should be made of five or six needles. After the introduction of the needles the nævus is seen to whiten at once. A permanent cure is believed to be obtained by this means. *Ibid.*

Digitated Stockings.

We are inclined to think that digitated stockings—that is, stockings with a stall for each toe—would conduce much to comfort, and spare many persons who now suffer from the development of soft corns between the toes a serious trouble. They would also prove more cleanly than the stockings in common use, because they would naturally absorb and remove the acrid moisture which accumulates between the toes, and which is the general cause of offensive odors from the feet. They will, moreover, give the foot better play, allowing its phalanges greater freedom of action. And lastly, a well-fitted digitated sock or stocking will remove a mass of material from the toe of the boot, and at the same time give increased breadth and space for expansion across the base of the toes. The new stockings, supposing them to be well cut and fitted, possess many advantages.—*The Lancet.*

Pediculi Capitis.

A solution of hydrarg. chlorid. corrosiv. in dilute acetic acid (gr. ij to ʒj) destroys both pediculi and nits in one application. The use of warm water and soap subsequently obviates any danger from absorption of the mercury. —*Med. Times.*

Noma Pudendi.

In the October number of the *New York Medical Journal and Obstetrical Review*, Dr. ANNA LUKENS reports a case of noma pudendi, which terminated

in recovery. The patient was a female child, mulatto, three years of age, previously healthy, excepting an attack, when two years old, of acute articular rheumatism, complicated with endocarditis, from which she recovered with permanent mitral insufficiency. For six months previous to her last attack of illness the child's general health was remarkably good. On May 10, 1882, it was reported that she had been very restless and feverish, having had a chill the previous night. Attention was directed to the genital organs, which, upon examination, revealed a condition closely resembling aphthous vulvitis. The patches covered nearly the entire mucous surface of the labia majora and surrounding parts. The whole surface was of a grayish color, and covered with a thin gray discharge exhaling an exceedingly fetid odor. Sloughing of the parts occurred soon after, and increased rapidly involving the perineum and extending back beyond the sphincter ani, and for more than an inch behind the anus. The inguinal glands were not affected.

The general condition of the child at this time was very unfavorable. There was great prostration, with complete loss of appetite, thirst, restlessness, and high fever, the temperature in the rectum ranging from 101.5° F. in the morning to 104° in the evening. The pulse was feeble, small and frequent. The parts were swollen and extremely sensitive. Micturition was painful. This condition continued for three days, when a detachment of the eschars occurred, leaving a deep furrow on each side of the anus, with sharply defined, irritable edges. The right labium continued swollen and gangrenous for several days later. The constitutional symptoms began to subside soon after the separation of the slough occurred. Healthy granulations sprang up, and the healing process went

on quite rapidly. In three weeks from date of attack the entire surface was healed, but not without considerable deformity. The sphincter ani was entirely destroyed, also a portion of the perineum. An irritable ulcer occurred within the rectum.

The local treatment consisted, first, in bathing the parts with carbolized water, afterward dusting them thickly with iodoform, with no other effect than correcting the fetor. Balsam of Peru was next applied, but with no better result. After this a preparation consisting of equal parts of pulverized gum, camphor, and balsam of Peru was applied twice daily, and the parts were covered with carbolized cotton and bandaged. The latter treatment gave apparently excellent results, as the progress of the disease was arrested, and the slough began to separate soon after and was rapidly detached. The constitutional treatment consisted in giving tincture of the chloride of iron and chlorate of potassium with quinine and stimulants.

Noma was not recognized by the older writers, but was, according to Bamberger, first described by Battus, a Dutch physician, in the beginning of the seventeenth century. The disease is one of unfrequent occurrence. West observed but seven cases among thirty thousand sick children, six of which terminated fatally. Vogel remarks that he has seen but five cases, of which only one ended in recovery. He also states that from eighty to ninety per cent. of the patients with noma perish in a few days. Noma pudendi appears to be of even rarer occurrence than noma of the mouth, or cancrum oris.—*Med. Record.*

DISEASES OF THE EYE AND EAR.**Pilocarpin a Cure for Night-Blindness.**

Pilocarpin exerts a stimulating influence upon the retina. Dr. Mecklenburg (*Berlin. Klin. Woch.*) gives this case: A strong and healthy male prisoner, twenty-four years old, who had never previously suffered with his eyes, suddenly became night-blind; as soon as dusk set in he could see nothing. It was a case of hemeralopia. The pupils were greatly enlarged, but nothing else was abnormal about the eyes. After the usual means had been tried, Dr. M. injected, subcutaneously—R. Pilocarpinæ muriat., gr. iss.; aquæ destillatæ, m lxxv. Sig. Inject twenty-five minims. The improvement was immediate, and after the third injection the patient was well.—*Med. and Surg. Reporter.*

Syphilitic Iritis.

Mr. J. R. WOLFE, Surgeon to the Glasgow Ophthalmic Institution (*London Med. Times and Gazette*): After the administration of pil. hydr. c. colocynthis, I order small doses of ol. terebinth., one tablespoonful three times a day; in syr. aurantii. This I continue for three or four days, with warm drinks, foot baths, etc. Then I order pil. hydrar. c. quinia three or four times a day, and the unguent, hydrar. fort., into the armpit, one drachm every evening; warm baths twice a week. When the gums begin to get tender I discontinue the pills, and only apply the unguent hydrar. to the axilla, and internally, potassium iodide is ordered. Should symptoms of mercurialization supervene, I discontinue the ointment and keep the patient exclusively to the potassium iodide, which may be given, one scruple, three

times a day. The strong atropine solution, with the gray ointment, is continued for a considerable time. The drops may even be persevered with for a month after the general inflammatory symptoms have disappeared.—*Braithwaite's Retrospect.*

Conditions Under which Foreign Bodies Have Been Observed to be Tolerated in the Background of the Eye.

These are stated by Dr. KNAPP (*Archives Ophthalmology*, thus:

1. The size of the foreign body, with one exception, did not exceed 2 mm. in its greatest diameter. In Graefe's first and second cases it was about as long as the diameter of the optic disc and scarcely half so broad. In Jacobson's case the corneal scar was, 1½ hours after the injury, about 1 m. long, the ophthalmoscopic dimensions are not stated—"a small dark body was seen." * * * In Jacobi's case the thickness was 0.75 mm., the length could not be determined, as it was impossible to know how deep it penetrated into the membranes. In Hirschberg's first case the corneal scar three days after the injury was 1 m. long; the body, ophthalmoscopically determined, was about 2 mm. long; in his second case it was 2 mm. long and 1.5 mm. broad. In Strawbridge's case it had the size of a pin-head. In Snell's case it was about 1.25 mm. long and 0.75 broad. In Hirschberg's third case it was about 1 mm. long and 0.50 mm. broad. In our case it was 1.5 mm. long and 1 mm. broad. The foreign body in Grafe's third case was exceptionally large, "at least 2½ m. long and 1 m. broad. It produced an irregular corneal scar of 1 m. in length, and must have pierced the cornea in the direction of its longest diameter."

2. The substance of the foreign body was iron or steel in all cases except two: that of Jacobson, in which a miller, while sharpening a mill-stone, injured his eye by a piece of stone flying off, and that of Brière, in which it was copper, a fragment of a gun-cap.

3. The parts traversed by the foreign body were the cornea, iris, and lens in the majority of cases; the sclerotic, ciliary body, and, choroid in some; the vitreous, of course, in all.

4. The reaction of these parts, produced by the traumatism, was a readily cicatrizing wound in the cornea and sclerotic; perforation and cicatrization, with or without transient inflammation, in the iris; stationary or progressive opacity in the lens, necessitating the subsequent extraction of cataract; diffuse and floating opacities in the vitreous, clearing up in most cases, partially remaining permanent in some.

5. The lesions in the fundus were circumscribed laceration of the retina and choroid, and hemorrhage; no detachment. In one case (Snell) the retina was intact, the foreign body adhering to its inner surface.

4. The reaction in the membranes of the fundus was circumscribed thickening of the retina, circumscribed irregular pigmentation and superficial atrophy of the choroid; in one case (Jacobi) hypertrophy of the chloridal pigment is mentioned, but, to judge from the black appearance of the foreign body in our and other cases, this is not beyond doubt. In all cases there was transient, more or less severe ophthalmitis.

7. The foreign body was situated in one case (Snell) on or in the inner layers of the retina; in the majority of cases it penetrated the whole thickness of the retina, in some the retina and choroid;

in one it was said to stick in the sclerotic.

8. In most cases one end of the foreign body projected into the vitreous, up to 1 mm. or less in height; in some its inner surface was at the level of the retina. The inner end was either perfectly free, or incompletely covered with delicate cords of connective tissue, or the whole foreign body was encapsuled (Jacobi Brière).

9. The retinal border of the foreign body was surrounded by connective tissue, which in some cases (Snell, for instance) was very scant; in others (Hirschberg's and ours, for instance) it formed a bright, white, tendon-like ring of characteristic appearance. This ring and the scanty cords arising from it seemed to be the main supports of the foreign body.

10. The functional disturbances consisted at first in obscuration of the visual field and impairment of vision, later in a permanent scotoma corresponding in location to the foreign body, but being mostly larger than could be expected from the ophthalmoscopically determined size of the foreign body or the lesion in the retina, because not only the pericipient elements of this spot, but also the nerve fibres passing through it, must have been destroyed. In one case (Snell) a defect in the visual field could not be detected, but, as Hirschberg remarks, it would have been found had the field been perimetrically examined.

The central acuteness of vision was more or less good in all cases; in some (Jacobi, Hirschberg, Snell, Gruening, and ours), it was normal.—*Detroit Lancet.*

THE AMERICAN MEDICAL DIGEST.

PART III.

Diseases of Women and Children,
and Obstetrics.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Restoration of the Cervix Uteri and Perinæum, by operating upon both at the same time.

BY A. J. C. SKENE, M. D.

The coëxistence of laceration of the cervix uteri and perinæum frequently comes to the notice of the gynæcologist, and hence the management of such cases becomes an important question of every day practice. When all the circumstances are favorable it is most convenient for the surgeon to first restore the cervix uteri, and subsequently to operate upon the perinæum. It is perhaps better for the patient also to follow this plan, because it is more likely to give final success. This point is not definitely settled, however. Granting, for the present, that it is best for all parties concerned to restore the cervix before beginning the treatment of the perinæum, still there are circumstances which compel the gynæcologist to do both operations at the same time. Hospital patients, who are poor and having homes and children to care for, can ill afford the time for prolonged treatment. The same may be said of private patients in moderate circumstances. Such conditions as these are strong reasons in favor of doing both operations at once. Again, this plan requires the patient to be anæsthetized but once, which is a great advantage. A saving of about one-half the usual time to the patient and operator is the chief advantage which may be claimed for doing the two operations at once. The objections, on the other hand, are the difficulties in the way of managing secondary hemorrhage, should it occur; the

impossibility of watching the cervix during the healing process, and employing any after treatment which might be necessary, and finally the injurious results arising from leaving the sutures so long in place, it being impossible to remove them until the perinæum has completely healed. Now, regarding the first two objections, they should have little weight in this matter. Secondary hemorrhage is so rare after restoration of the cervix, if proper care is taken in the operation, that it may be dismissed. Regarding the after treatment of the cervix, very little is required as a rule. In the majority of operations, vaginal injections only are used, and they are generally useless. It will be observed, then, that the chief difficulty is with the sutures, and that is, or has been, a valid objection. The silver wire suture, if left in the cervix for three weeks (the time required before their removal is safe, when the perinæum has also been operated upon), causes inflammation and ulceration of the cervix or vagina, or both. This may not occur to any troublesome extent if the twisted ends of the sutures are cut short and laid down close upon the surface of the tissues. But in this case they are liable to become imbedded so that their removal is difficult. In nearly all cases the silver wire gives trouble, if left so long in place. To obviate this—the most important objection to doing both operations at one time—a suture is required which can be left in the cervix with impunity for three weeks or a month. For years I have used silk sutures in restoring the cervix uteri, and have found that they can be left in the

tissues a long time without causing much irritation, and therefore they answer the purpose fairly well.

I have operated quite a number of times in this way, leaving the sutures in the cervix until the perinæum had sufficiently healed to permit their removal with safety. The presence of the sutures in the cervix gives no trouble, but their loose ends, lying in the vagina, has caused a slight vaginal leucorrhœa in some of my cases. This has really done no harm, but I have found that it might effect the healing of the perinæum.

In order to avoid any possible harm from the silk suture, I have used the Japanese sutures, made of whale sinew. This material answers the purpose perfectly. It is absorbed in a week at least, so that by the time the perinæum is healed firmly enough to permit an examination of the uterus with the speculum, the sutures used in restoring the cervix have all disappeared.

My experience with this kind of suture has been as follows: I first used two of the six sutures in restoring the cervix, one on each side. The other sutures used were new silk. At the end of a week, when I came to remove the sutures, I found the ends of the Japanese sutures in the vagina, the portion included in the tissue, had all disappeared.

In my next case (in which the cervix and perinæum were both operated upon at the same sitting), I had only two silk sutures, and all the rest Japanese. The sutures were removed from the perinæum at the end of a week, and at the end of three weeks the cervix was examined and the two silk sutures were found in place, but there was not a trace of the Japanese sutures to be found. The restoration of the cervix was as perfect as I have ever seen, either in my own practice or that of others.

In my next case, in which the two

operations were performed together, Japanese sutures were used exclusively in the cervix. At the end of the third week the cervix was healed completely, and the sutures had all disappeared. At first I was afraid that these sutures might be absorbed before the parts healed, but I know that in restoring the cervix, union takes place in a few days, if it is obtained at all; hence I presumed the Japanese sutures would hold as long as was necessary. Subsequent observation confirmed that belief, and now I restore the cervix and perinæum, and give no attention to the cervix until a month after the operation, when an examination is made to see what the result is. So far I have every reason to be satisfied with the Japanese suture for the purpose herein described. In restoring the cervix alone, in which case the sutures can be removed at the end of a week, I do not know that the Japanese has any advantage over silver wire or silk, although I presume it is as good as either of the others.

Amenorrhœa.

In cases of this nature, due to torpid action of the ovaries, Dr. GOODELL orders the following prescription:

R. Ex. aloes, 3 j.; ferri sulph. exsic, 3 ij., assafœt. 3 iv. M. et in pil. No. c, divide. Sig.—One pill to be taken after each meal. This number to be gradually increased, first to two, and then to three pills after each meal.

If the bowels are at any time over-affected, the patient is to stop and begin again with one pill.

Where the amenorrhœa is due to arrested development, Dr. Goodell has derived the very best results from the constant use of Blot's pill, as recommended by Niemeyer:

R. Pulv. ferri sulph., potas. carb. puræ, āā 3 ij., mucil. tragacanth. q. s.

M. et in pil. No. xlviij, div. Sig.—To be given daily, in increasing doses, until three pills are taken after each meal.

This gives the large quantity of twenty-two and a half grains of the dried sulphate of iron per diem.

If these pills give rise to constipation, Dr. Goodell uses this formula:

℞. Pulv. glycyrrh. rad., pulv. sennæ, āā ʒ ss., sulphur sublim., pulv. feniculi, āā ʒ ij., sacchar. purif. ʒ jss. M. Sig.—One teaspoonful in half a cupful of water at bedtime.

Where the suppression is due to change of habits and loss of health, tonics are employed. When the suppression comes on suddenly, from cold or exposure while in the midst of the menses, and is accompanied by severe lumbar pains, the patient is placed in a mustard hip-bath, a Dover's powder is administered, she is put to bed and hot drinks are given to provoke copious diuresis and diaphoresis.—*N. Y. Record.*

Treatment of Amenorrhœa.

WILLIAM R. D. BLACKWOOD, M. D., writes in the *Medical Bulletin*:

Strychnia affords excellent results in many instances. A favorite with me is the following:

Strychnia sulph., gr. j.; cinchonidia sulph., ʒ j.; ferrum per hydrogen, assa-fœtida pulv., āā ʒ ij.; ext. quassia, q. s. M. In pil. No. 60 div. Sig. One four times daily.

I usually add at bedtime ten drops of Squibb's fluid ext. ergot in water; and a forcible jet of cold water along the spine every morning on rising for a few minutes, with brisk friction of the abdomen, succeeds admirably in many cases. Exercise in the open air, equestrianism particularly, with attention to a normal action of the skin, kidneys, and bowels is essential.—*Canada Med. Record.*

Nitrate of Aluminium in Pruritus.

Nitrate of aluminium (*American Practitioner*) dissolved in five to ten parts of water is claimed to act well in pruritus. As it crystallizes with difficulty it is best in the form of a fifty per cent. solution: Ten and one-half parts of dry aluminium hydrate are dissolved by digestion in sixty-five parts of pure nitric acid, specific gravity, 1.180; the solution is diluted with one hundred and ten parts of water, filtered and then kept in glass stoppered bottles. Two parts of this solution are equal to one part of the crystallized salt.—*Chicago Med. Review.*

Treatment of Vulvar Pruritus.

M. BERNIER (*Journal Med. et de Chir. Pratiques*) after trying all forms of application in a case, found that most benefit was obtained from the following unguent:

℞. Ung. diachylon simpl. (Fr. cod.), ol. olivæ, āā equal parts. M.

On the other hand, M. Delaporte, recommends, in the same pruriginous affections, the following lotion:—℞. Sodæ carbolat., ʒ ss.; aquæ colon., ʒ iiss.; glycerinæ, ʒ iiss.; aquæ, ʒ x. M.

Lotions with this wash should be made whenever irritation is intense, and particularly at bedtime. The liquid should be applied cold, with a fine sponge.

Treatment of Pruritus Vulvæ.

ALFRED WILTSHIRE, M.D., F.R.C.P., says: Many cases of pruritus vulvæ are promptly relieved by a borax lotion, and it is well to use this simple and efficacious remedy where not contraindicated. A drachm to five ounces of warm water is a good standard strength, but a stronger solution is usually needed, seldom a weaker. Hydrocyanic acid may be added—say ʒ j. of the dilute acid to ʒ x., or morphia (gr. ij.), atropia (gr. ʒ),

aconitia (gr. $\frac{1}{2}$), or veratria (gr. $\frac{1}{2}$). Infusion of tobacco (half an ounce to the pint) alone relieves some cases, and forms a good vehicle for borax or boric acid. It is not well to use glycerine with the borax as a rule, as it is apt, owing to its affinity for water, to aggravate the irritation. Some find relief from chloral lotions, but the drug has not always suited. Strong decoction of poppy is a soothing vehicle for borax, etc. Ice alone will relieve some; while others can get relief only from the use of very hot water. In excessively severe cases, the ether-spray might be tried.

Boric acid is an excellent remedy; but, being much less soluble in water than borax, is not so handy as a lotion. It may be combined with hydrocyanic acid, morphia, atropia, aconitia, veratria, etc. In the form of ointment, where fats do not disagree, it often soothes greatly. A non-rancid fat should alone be employed as the vehicle, *e.g.*, freshly made spermaceti cerate, vaseline, fossiline, or purified benzonated lard, etc.

Lotions of iodine occasionally answer, *e.g.*, two drachms of iodine in ten ounces of elder flower water. Electricity may afford relief in neural cases. Probably faradism would be the preferable form.

In simple vulvitis, lead, borax, or carbolic lotions relieve. An ointment of calomel or bismuth is also good. Malignant affection of the parts calls for appropriate treatment, such as ablution, where practicable; but sedative applications (conium, opium, belladonna) alone are often all that we can employ.—*Canada Lancet*.

Uterine Electro-Therapeutics.

Dr. J. DIXON MANN (*London Lancet*) says: Electrical treatment is only useful when the causative defect is in the gen-

erative system and the organism as a whole is healthy.

The treatment of necessity must be prolonged in most instances, thus requiring patience on the part of both physician and patient. An ill-nourished or ill-developed organ cannot be immediately brought to a performance of its function. The organic defect must first be remedied. Imperfect nutrition demands prolonged use of the constant current: simple atony commonly yields to a much shorter application of the induced current. The necessary instruments for uterine electro-therapeutics are: an insulated sound (two sizes), a cervical electrode, and two or more large disc electrodes. The sound is coated with gold in its curved part, or is made of solid platinum, which is better. The stem is to be insulated to within two inches of the end by covering it with a gum-elastic catheter. The external electrode is an oval disc of flexible metal, with a layer of amadou on one side and covered with wash-leather. Dr. Mann relates three cases treated with electricity. One of these was a case of amenorrhœa, with imperfectly developed uterus, measuring only $1\frac{1}{8}$ in. Applications during fifteen minutes twice weekly of the constant current from twenty-five cells were made for some time. At the end of five months the uterus measured $2\frac{1}{4}$ in., and the patient menstruated for the first time. After this she was regular. The applications were now made at longer intervals, the induced current being used when the symptoms indicated approach of the menses.

The second case was one of amenorrhœa following a severe illness. Both currents were used, and at the end of two months the menses returned and continued to be regular.

Dr. Mann further relates a case of spasmodic or neuralgic dysmenorrhœa,

the pain being intense for twenty-four hours before the appearance of the discharge, and attended with vomiting, successfully treated by intra-uterine applications of the constant current. In this case there was neither flexion nor congestion. The sound was easily passed, but caused much pain. The application of about eighteen to twenty cells were made three times a week. At the first period there was no vomiting and much less pain. Treatment was resumed in the interval. At the next period she was so much better that she declined further treatment.—*Amer. Journal of Obstetrics.*

New Treatment for Vaginitis.

M. TERRILLON proposes a method of treatment which consists essentially in the introduction into the vagina of the following ointment:

R. Ac. tannic, 50 grams; amyli, 150 grams; ung. petrolei, 150 grams.

M. This ointment is placed in a sort of speculum, so arranged that the ointment can be forced out as the instrument is withdrawn from the vagina. If the vulvar opening is large a small tampon of cotton may be introduced.

Generally from fifteen to twenty grams of the unguent is sufficient at one application, and it need not be repeated for seven or eight days.—*Med. and Surg. Reporter.*

Oöphorectomy.—Battey's Operation.—Spaying.—Castration of Women.

BY DR. ROBERT (*Amer. Jour. of Obstet.*).

Ultimate results.—1st, Aphrodisia.—Patients who have been subjected to the operation have not in any case complained of the loss of this power, but on the contrary they have, in a number of instances, borne testimony to their full competency. 2d, Female graces.—These have not been impaired in any case, but a positive gain has often been noted.

3d, General health.—As the operation is proposed only as a *dernier ressort* and in cases of a desperate character, whatever of benefit is to be secured is to be accounted so much actual gain. It is hypercritical to object that some of the cases are not benefited and others are not wholly cured. Comparing the cases tabulated as complete operations, we find:

Cured, 68—75 per cent.; greatly benefited, 15—17 per cent.; not benefited, 7—8 per cent.

Of the incomplete operations:—Cured, 3—18 per cent.; greatly benefited, 7—41 per cent.; not benefited, 7—41 per cent.

In several instances where the results were unsatisfactory for some months (or even a year or more), the patients were subsequently much improved, and a few were even completely cured. It is premature to set down any case as a failure until ample time has been allowed for the cyclical change to have become complete in its entirety.

Capsicum in Uterine Hemorrhages.

Dr. J. CHENON (*Le Progres Medicale*) says: From a large number of physiological experiments I concluded that capsicum is a vascular remedy, acting especially on organs whose circulation is singularly active, such as the utero-ovarian, respiratory and encephalic. Cayenne pepper acts like ergot of rye on the smooth fibre of the vascular coats, either directly or through the vaso-motors. But it presents a great advantage over ergot, in that it is well borne by the stomach, whose functions it simply stimulates. I have used it for several years in uterine hemorrhages with the best success, whether these hemorrhages were due to fibroid tumors, fungous endometritis, or even to epithelioma. The formulæ at which I have arrived are as follows:

℞. Powdered capsicum, 5 grammes. Make thirty pills. One before each meal, increasing to six pills a day.

℞. Aqueous extract of capsicum, 5 grammes. Make thirty pills. To be given in the same dose as No. 1.

℞. Tincture of capsicum, 5 grammes; rum, 30 grammes; gum julep, 120 grammes. Take by spoonfuls every two hours.

I have also successfully used capsicum in congestive headaches so common in the gouty, and in the hæmoptysis of tuberculous patients.

The Local Treatment of Chronic Metritis.

Most cases of chronic metritis require local treatment for their cure. If the disease be limited to the mucous membrane of the cervical canal, the treatment is comparatively simple, and cure can be effected by various harmless means. Greater difficulty is met with when chronic inflammation of the body or of the body and neck of the uterus calls for local treatment. This is new only in the manner of its execution, and consists in the systematic cauterization of the cavity of the body, and eventually of the cervix of the uterus, by means of an instrument like a sound, into a hollow in the upper end of which is fused *lapis mitigatus* (argenti nitras, weakened by the addition of nitrate of potash). This can be employed, as is self-evident, according to the behavior of the endometrium, and the resisting power of the uterus in individual cases, at one time more frequently and thoroughly, at another more rarely and cautiously, and will have, according to the peculiarities of the special case, by itself alone, or in conjunction with other means (topical blood-letting, scraping off of growths of the endometrium), almost sure results. Only in a few cases of large tumors or severe bleeding gran-

ulations of the endometrium is the employment of the galvano-cautery or thermo-cautery necessary. The intra-uterine application of lapis mitigatus is with the necessary caution, absolutely free from danger, and in a small number of cases only does it cause pain, which, however, usually is of short duration; sometimes, also, it gives rise to considerable but transient bleeding. Once only have we noticed, after a severe cauterization of the whole of the uterine cavity, dangerous metritis or peri-metritis, which, however, ended in a few weeks in complete recovery.—*Amer. Journal of Obstetrics.*

An Improved Method of Treating Uterine Displacements.

Dr. ROBERT BELL of Glasgow, gives the result of his experience in the treatment of uterine displacements by vaginal tampons of cotton-wool soaked in a solution of alum and carbolic acid in glycerine.

Dr. Bell's solution is the following: Glycerine, 80 oz.; alum, 10 oz.; carbolic acid, 1½ oz. This solution, it will be observed, theoretically—and Dr. Bell claims to have found, practically—fulfils most desirable indications. The glycerine depletes, and so lessens congestion by its affinity for water; the alum constricts, and so braces up the vaginal walls; and the carbolic acid, by its antiseptic properties, renders it possible for the cotton to be retained for a convenient length of time. He usually employs only one large tampon, but in some cases of flexion, uses two—a small one pushed well up in front or behind the uterus, and a larger one beneath it. In the case of prolapsus, if there be laceration of the perineum, this must first be rectified. The uterus is elevated as nearly as possible to its normal position, and there retained by a suitable-sized tampon of cotton soaked in the solution.

This can be retained for three or four days without becoming offensive, on account of the antiseptic ingredient. He claims to have seen patients thus completely cured of procidentia, which had existed from three to eight years, by perseverance in the treatment for from two to seven months.—*Can. Med. and Surg. Journal.*

Treatment for Acute Ovaritis.

Neptune's belt, leeches to the vagina, saline cathartics, quinine, opium till every trace of tenderness has disappeared and the ovary can no longer be felt. Vedeler was unable to decide as to the merits of gold salts, which Noeggerath regards as specific. Chronic ovaritis is difficult to cure, and relapses readily occur. Among internal remedies, most benefit was obtained from bromide of potash and ergotin combined, and given in pills. Externally, turpentine to the abdomen, after which a Neptune's belt was left on all night, and a woolen bandage was worn over the abdomen through the day. Leeches were used at the commencement of the treatment, and later on when there was great tenderness or pain. Generally two were applied to the vaginal arch on the diseased side. Every other day the vaginal arch was pencilled with superiodide of potash. A suppository of equal parts of opium and extract of belladonna was placed in the vagina every evening.—*Norsk. Mag. f. Lægevidenskaben og Nordiskt Med. Arkiv*, vol. xii., No. 27.—*Med. Record.*

Pregnancy and Adhesions after Ovariectomy.

Dr. WALTER F. ATLEE (*Am. Jour. Med. Sci.*) relates an interesting and singular case, where mother and child died during labor from difficulties attributed to shortness of the pedicle, secured by a clamp, in ovariectomy.

A cystic colloid of the left ovary, nine pounds in weight, had been removed in 1875. The very short pedicle was secured by clamp—recovery was rapid. One small place about the centre of the scar never healed, and through this (the pedicle) the patient menstruated. Having become pregnant, in February, 1880, she was taken in labor. Though in labor five days, the os had dilated to the size of a quarter of a dollar only. Digital dilatation was resorted to and the forceps applied—occiput to the left sacroiliac synchondrosis, and body back forward, as it should be in first position of the vertex. It was impossible to make the head advance. After much fruitless effort the child was found to be dead, and the mother, having lost forty ounces of blood and taken twelve ounces of ether, died shortly after, undelivered. The difficulties were attributed to irregularity of contraction in a deformed womb, in consequence of the left horn being fastened by a very short pedicle to the abdominal wall just above the pubes.

Nitrate of Lead in Ulcerated Cancer of the Uterus.

M. CHERON, in the *Revue des Maladies des Femmes*, remarks that he was led to employ nitrate of lead in the treatment of ulcerated epithelioma of the cervix uteri by the good reports from Italy regarding the benefits obtained from this drug in ulcerated cancer of the organ.

DISEASES OF CHILDREN.

On Subcutaneous Nodules Connected with Fibrous Structures Occurring in Children, the Subjects of Chorea and Rheumatism.

TOMAS BARLOW, M.D., F.R.C.P., and FRANCIS WARNER, M.D., M.R.C.P. The nodules described vary in size from that of a mustard seed to that of a bitter almond.

They are strictly subcutaneous, the skin over them being simply raised, and without any heat, pain, redness, or infiltration.

In most situations they are slightly movable.

They occur in connection with fasciæ and tendons, and especially near joints.

The back of the elbow, the malleoli, and the margins of the patella are the commonest sites.

Other situations are the neighborhood of the vertebral spines, the spine of the scapula, the *cresta ilii*, the extensor tendons of the foot and hand, the temporal ridge, and the superior curved line of the occiput.

They are mostly symmetrical.

In regard to minute structure, they consist of small masses of loose fibrous bundles, sometimes very vascular.

In regard to evolution :

1. These nodules may appear in one crop, *i. e.*, several nodules appear simultaneously in different parts of the body.

2. Successive nodules may appear.

3. The nodules subside generally within a period of two months.

4. They may partially subside, and then undergo recrudescence.

5. After complete subsidence, so far as manipulation can determine, a new crop may appear.

6. They never become bony, and never become infiltrated with urate of soda.

7. Their evolution is not attended with pain, and rarely with marked pyrexia. Often during the time when they are present there is no pyrexia.

These nodules are to be clearly distinguished from—

- (a.) The *nodi digitorum* of Heberden.
- (b.) Gouty nodules.
- (c.) Erythema nodosum.
- (d.) Syphilomata.
- (e.) Scrofulides.

In regard to age, they have been observed by us only in children and young adults, the limits being $4\frac{1}{2}$ years and 19 years.

In regard to sex, out of 26 cases 17 were female, 9 were male.

In all the cases it was believed there was heart affection.

Thirteen out of the 26 cases had well-marked chorea; 8 had erythema marginatum, or erythema papulatum; 1 had purpura in addition.

There was a history of acute rheumatism in 10, and of subacute rheumatism, with vague joint-pains, in 8.

It is admitted—

1. That these subcutaneous nodules may be taken as indicative of rheumatism in children.

2. That when found associated with heart disease and chorea, although no history of rheumatic fever can be obtained, nevertheless their presence gives a presumption that the chorea is rheumatic.

3. That in regard to prognosis and treatment, although the nodules are unimportant in themselves, they are, nevertheless, of serious import, because in several cases the associated heart disease has been found actively progressive.

4. That in nature they are probably homologous with the inflammatory exudation, which forms the basis of a vegetation on a cardiac valve.—*Internat. Med. Cong.—Amer. Jour. of Obstetrics*, vol. xiv., No. 4.

Treatment of Leucorrhœa in Children.

Leucorrhœa in children, says M. BOUCHUT (*Practitioner; from Le Praticien*), is caused by vulvitis, not vaginitis or metritis. He therefore treats this condition by extreme cleanliness, repeated bathing with bran-water and lead-water, lotions of corrosive sublimate (two grains to ten ounces of water), caustolic

acid (two grains to the ounce), and occasionally solution of nitrate of silver (three grains to the ounce). In the intervals of applying the lotions a pledget of lint saturated with coal-tar or an ointment of red precipitate may be placed between the labia. Such a pledget kept in place by a pad protects the surrounding parts as well as the labia themselves from the irritating secretion, which is often present in considerable quantities. For the general treatment M. Bouchut recommends the administration of cod-liver oil and quinine to strumous patients, and of arsenic to those with eczematous eruptions.—*Canada Med. Record.*

Iodoform in the Vulvitis of Children.

Prof. PARROT applies iodoform by means of a badger's hair-pencil at whatever stage the apthæ may be in, covering the parts affected with a thick layer of iodoform without previous cleansing, and then applying a little charpie. This dressing is repeated every twenty-four hours, until amendment takes place, which it usually does very rapidly. Even after the first application it is rare not to find a considerable improvement. The ulcerated parts look as clean as if they had been carefully washed. Their borders sink and their cavities fill up, and when they are not very extensive they are not easily distinguished from the surrounding parts.—*Med. & Surg. Reporter.*

Acute Laryngitis in Infants.

In ordinary cases the yellow sulphate of mercury, prescribed in powder in two-grain doses, may be administered as an emetic. The atmosphere which the child breathes should be constantly loaded with moisture, without, however, that degree of heat which would add materially to the discomfort of the patient. Moist air promotes expectoration and renders

the cough looser. A temperature of 75 deg. to 80 deg. F. is required.

The following will be found a most efficient solvent for the pseudo-membrane, and should be used in the steam-atomizer :

R. Calcis, ℥ ss., 15.00 gm.; aquæ, fl ℥ viij., 240.00 gm.; glycerinæ, ℥ ij., 60.00 gm. M.

Each second hour one ounce of the following should be used, the lime-water being used constantly between times :

R. Potass. chlorat., ℥ ij., 8.00 gm.; amm. muriat., ℥ j., 4.00 gm.; glycerinæ, ℥ ij., 60.00 gm.; aquæ, ℥ vj., 180.00 gm.

The inhalations may be continued for two hours without wearying the child.

If the temperature is high, quinine should be given in two or three large doses.

As regards local measures, cold water may be constantly dropped from a sponge upon a compress laid over the throat of the child, or two or three thicknesses of muslin soaked with camphorated oil may be applied over the larynx so as to cover the neck in front, and over this a bladder containing pieces of ice, or ice surrounded by oil-silk, to prevent dripping. If oxygen be obtainable, the inhalation of this agent will be found to relieve the dyspnœa.—*Prof. J. Lewis Smith—Louis. Med. News.*

Benzoate of Soda in Whooping Cough.

D. TORDEUS, of Brussels, writes that he has prescribed the benzoate of soda in a number of cases of whooping-cough, and that in all the cases the parents reported that the coughing fits began to diminish in force and frequency after one or two days of treatment. He gives four grains of the salt every hour to a child of two or three years. The drug seems not alone to diminish the force and frequency of the paroxysms, but also to exert a favorable in-

fluence on the mucous membrane of the respiratory tract, and to prevent the development of serious pulmonary complications.—*Journal de Med., etc., de Bruxelles.*

Treatment of Pertussis.

Dr. NEUBERT (*Jahrbch. f. Kindhlkde.* XVII. B., I. H.) refers to preceding articles on this subject, and especially to his own article, published in Vol. XIII of the *Jahrbuch*, in which he reported the treatment of pertussis by inhalation every two hours of a spray of a one per cent. solution of salicylate of soda. Dr. Thomsen, in Copenhagen, took up the same treatment, and reported on it in Vol. XIV. In the winter of 1879-'80, Dr. Thomsen again had good opportunity to try the treatment, and his results were very favorable. The course of the disease was shortened, instead of the usual six to eight weeks, to five weeks or less. Of ten cases which came under treatment up to a week and a half after the commencement of the stadium convulsivum, seven healed in three weeks or less, one in three and a half weeks, one in five weeks, and one remained unhealed. Of the other nine, five healed in three weeks, one in five, and three not at all. The number of the paroxysms decreased rapidly, and the vomiting frequently stopped as soon as the inhalations were begun.—*Am. Jour. of Obstetrics.*

Spasmodic Croup in Children.

In the treatment of laryngismus stridulus, Prof. WALLACE highly approves of large doses of potassium bromide, given every hour or two; for a child two years old, he would give six grains every two hours. It may be given in syrup of wild cherry, or in the form of elixir of potassium bromide, which is made by

the pharmacists generally.—*College and Clinical Record*, Vol. ii., No. 2.

Case of Trismus Nascentium.

BY CHARLES L. GWYN, M. D.

(*Mich. Medical News.*)

July 24, 1880.—I was called this morning to see the infant child of C. R., age less than one day, and found it suffering from lock-jaw and spasm of the muscles of the right side. The posterior fontanelle was nearly closed, and I could feel the borders of the parietal bones overriding the occipital bone. The child had attempted to nurse but once, immediately after birth, and had the peculiar whining cry of children in its condition.

I used Dr. Sims' procedure of placing the child on its side, relieving the occiput of pressure, and ordered 1 gr. potassium bromide every hour to control spasmodic symptoms.

July 25.—Visited the child this morning and found it much better. The midwife, who is a woman of much more intelligence than usual, informs me that the child became quiet shortly after I left, has nursed several times, has had several stools, cries occasionally, and has a slight quivering of the muscles of the arm and leg of the right side; sensation does not seem to be impaired on either side; nervous symptoms yield readily to the bromide.

July 26.—Child much better; spasmodic contractions of the muscles diminishing; sleeps and nurses well; posterior fontanelle of normal size.

Dysenteric Diarrhœa.

For children, especially when teething:

R. Subnitrate bismuth, 2 drachms; syr. ginger, 1 ounce; mucilage of gum arabic, 3 drachms; creosote, 5 to 10 drops; camph. water to make 6 ounces.

Dose, one teaspoonful every three hours for a child one or two years old.

For children, in cases of dysentery or dysenteric diarrhœa while teething, the following may be used:

℞. Subnitrate bismuth, pepsin, tannin, pulv. cinnamon, āā, 2 grs.

As one dose every three hours in a child over one year old.—*Southern Med. Record.*

Infantile Diarrhœa.

For children belonging to families in easy circumstances, M. J. Guerin mixes a certain quantity of Belloc's powder of charcoal with each milk meal—half a teaspoonful at each meal. For the children of the working classes, Belloc's powder, which is a little dear, is replaced by very finely powdered, farina-like, ground baker's charcoal. This powder mixes readily with milk, and children drink the mixture as though the milk were pure. In a very short time, sometimes on the first day, the stools change in consistence and odor, and instead of being green, become blackish-yellow. At the same time that this addition is made, M. Guerin dilutes the milk with one-third or one-half of sweetened water, and the children take it without repugnance or vomiting. M. Guerin has frequently seen children, exhausted by seven or eight days' uncontrollable diarrhœa, regain in two or three days the expression of health.—*London Med. Record.*

Changes in the Spinal Cord in Infantile Spinal Paralysis and in Progressive Muscular Atrophy.

Drs. ROGER and DAMASCHINO conclude a very elaborate paper upon the lesions of the spinal cord in infantile spinal paralysis and progressive muscular atrophy. The authors conclude with the following résumé: 1st, the characteristic change in infantile paral-

ysis is a lesion of the spinal cord, resulting in atrophy of the nerves and muscles; 2d, the lesion is situated more particularly in the anterior portion of the gray substance of the spinal cord, where it evidences itself by foci of softening; 3d, this softening is of an inflammatory nature, and the disease is a true myelitis; 4th, infantile paralysis should accordingly be named spinal paralysis of infancy, and is to be nosologically classed among affections of the spinal cord as a myelitis; 5th, as for progressive muscular atrophy, this is to be differentiated from infantile paralysis as well by its symptoms as by its anatomical lesions. The change in the cord consists essentially in an atrophy of the motor cells, without any foci of inflammation.—*Revue de Médecine*, vol. xx., No. 16.—*Med. Record.*

Certain Emetic for an Infant.

℞. Pulv. ipecacuanhæ, gr. $\frac{1}{4}$ —1 sacchari albi quantum placeat.

Mix.—This may be repeated every twenty minutes until vomiting takes place. After one year of age the dose may be doubled. Or

℞. Vini ipecacuanhæ; syrupi, āā fl. $\frac{3}{4}$.

M. Sig.—Half a teaspoonful to two teaspoonfuls frequently, until vomiting is induced.—*Med. Gazette.*

The Treatment of Gastro-Intestinal Inflammation of Infancy and Childhood.

Dr. J. V. SPRING (*Mississippi Valley Med. Monthly*), after expressing his dislike for opium and astringents in this disease, sums up his treatment as follows: First, I have a tan bath prepared by boiling red or black oak bark until I get the ooze as strong as it can be made in a short time, then, while at a temperature of 75° or 80° Fahr., place the patient in the bath; have a sufficient quan-

tity in the tub so that it will come up to the shoulders while the patient is held in a sitting position, and keep him there until he becomes quiet, all evidence of restlessness giving way, which in some cases may take ten or fifteen minutes, then rub him well with a rough towel, give him a thorough rubbing with cod-liver oil from head to foot, place large cloths saturated with the ooze over the stomach and bowels, wrap him in flannel, and put him to bed, withdrawing all other treatment, keeping water and every character of nourishment out of the stomach. Repeat the bath and cod-liver oil every three or four hours, until all bad symptoms give way. Usually, I find improvement very perceptible after the third or fourth application, sometimes from the first. The patients usually sleep quietly for an hour or more after each bath, and with due care directed to the first nourishment taken or medicines exhibited, the little fellow will soon be convalescent.

A prescription that I employ, and find it answers the purpose in a large majority of cases, is this:—*R.* Subnit. bismuth; prepared chalk, āā ʒij. ; syrup bals. tolu, ʒj. ; aquæ menth. pip., ʒiv.

M. Sig.—Teaspoonful every three hours.

I sometimes substitute syrup ginger for the tolu, and when I find that quinine is indicated, direct each dose to be given in a teaspoonful of the above mixture.

Milk Indigestion in Young Children.

Dr. EUSTACE SMITH (*British Medical Journal*) says that when indigestion is due to catarrh of the stomach it is readily amenable to treatment. All that is necessary is to put a stop to the milk for a day or two, and to clear away the curd by a full dose of castor oil. If, however, the fault be in the milk, and

not in the digestive organs of the child, some change in the method of feeding is indispensable. In one case, where curdling took place, with resultant griping and indigestion, and where various remedies had failed, Dr. Smith at last adopted the plan of giving the child barley water from a bottle immediately before he took the breast, in the hope that by this means the milk might be diluted directly it reached the stomach. This method succeeded perfectly, and the child had no further unpleasant symptoms.

In cases of gastric catarrh, when the complaint is acute and severe, vomiting is usually the most prominent symptom. Under such circumstances milk becomes a positive poison, and no hope of alleviating the symptoms can be entertained while this diet is persisted with. In the case of an infant two months old, brought up by hand, and fed upon milk and barley-water, uncontrollable vomiting and diarrhoea had reduced it to the last extremity. Dr. Smith directed a weak mustard poultice to the epigastrium. The milk was stopped, and the child fed with weak veal broth and thin barley-water, mixed together in equal proportions, and given cold at intervals with a teaspoon. A few drops of brandy were given occasionally, as seemed desirable. As a result of this treatment, the vomiting stopped at once, and the child, when seen three days afterwards, was found to be much improved, and was cured by the end of a few days' further treatment. The most important part of the treatment in this case was the substitution of veal broth for milk. Directly the supply of fermentable matter was stopped, fermentation ceased, acid was no longer formed, and the digestive organs returned to a healthy condition. Here the derangement was acute.

Sea-Bathing—Its Contraindications in the Diseases of Children.

M. JULES SIMON (*Le Progrès Médical*) says: The question of the age of the patient is of primary importance. Old persons should not take sea-baths, nor even station themselves too long upon the shore, if they are subject to congestions. Such a stay may be fatal to individuals who have a predisposition to cerebral apoplexy. After the age of fifty or fifty-five years, sea-water bathing should be abandoned. The earlier periods of life offer also a general contraindication, and children under two years of age ought not to take cold baths; they may be sent to the seashore only to complete certain conditions of stimulation, but they must be restricted to ablution in cool sea-water. The treatment by salt-water bathing is of genuine service to children over three years of age, to youths and to adults, but I will now caution you as to the exceptions to be made, even at such ages.

Do not send to the seashore irritable patients, children in whom you observe the condition known as *cerebral irritation*, the issue of hysterical or epileptic parents.

Among adults, do not send to the seashore *plethoric cases*, with apoplectic temperament, or those suffering from *cerebral* or *spinal congestion*. The neighborhood of the ocean does not benefit *chorea*, and yet I sometimes make an exception in those cases in which the period of excitement has passed, and there remains only a slight debility.

Never consent to *hysterical patients* making even a simple stay at the seashore. Numerous personal observations have demonstrated to me that troublesome consequences may attend such a procedure. Judge for yourself, from the details of the following case: Two years ago, a young girl of eighteen years

was brought to Trouville, subject to grave attacks, which had rendered her general health deplorable; she could not eat, and her eyesight was rapidly failing. Alarmed at her constantly increasing debility, her mother concluded that she would take her to the seashore. Scarcely had she become settled there before the attacks burst out with extreme violence, and were prolonged during the night as well as the day. The poor, nervous sufferer had not a moment of rest; it seemed as if it was a perpetual convulsion.

The same observations may be made in regard to *epilepsy*.

Rheumatism offers another contraindication. You will read in the books that you may send to the seashore those wasted by this disease. I must raise my voice against this view. In the great majority of instances rheumatism does not tolerate proximity to the ocean, and a single bath may re-awaken all the symptoms.

While referring to rheumatism, I am led to speak to you of *cardiac affections*. Some children have these lesions in a minimum degree, but slightly appreciable or scarcely capable of detection, and yet a stay at the seashore may produce the most serious effects. The rhythm of the heart is disturbed, the circulation is embarrassed, and the important functions of the body are progressively altered. Organic affections of the heart, which make so little impression on the general circulation in children, become, at the seashore, a point of departure for stasis of blood in the lungs and the liver.

I have observed the same fact in adults suffering from cardiac disease, and in old persons suffering from induration of the orifices of the heart. We have here not only an inconvenience, but a real danger, which must not be

forgotten. To sum up, all those having affections of the heart, of the pericardium, or of the great vessels, should be interdicted from sea-bathing, and even from residence at the seashore.

A similar precaution should be taken in regard to those suffering from *albuminuria* and *Bright's disease*.

Cutaneous affections are not relieved by sea-bathing. Never prescribe such a treatment for acute or even for chronic affections of the skin. Be very sure that all itching dermatoses, depending on herpeticism or *dartre*, or arthritis, will receive from it a prejudicial increase in force.

Lupus of children, so often of scrofulous origin, which ought, one would think, for this cause, to be benefited by sea-bathing, or to receive an arrest of its progress through the employment of chlorinated waters, far from relaxing its destructive course, receives a powerful impulse from the saline water and salt air.

I may make the same remark in regard to the *ophthalmias* of a scrofulous character, and also to all chronic affections of the eye and of the eyelids.

For the same reason, it becomes necessary to prohibit a resort to the seashore to children affected with *chronic inflammation of the mucous membrane of the auditory canal*. You must not confound these purely superficial lesions with alterations in structure of the petrous portion of the temporal bone, and of the mastoid process, which, like all affections of the skeleton, find an element of cure in sea-bathing.

I need not insist upon so evident a point as the utter uselessness and the danger of a sojourn at the seashore to those suffering with such *organic affections* as cancer and tuberculosis.

Those suffering from chronic catarrh of the bronchi, emphysema of the lungs

and asthma should avoid the surroundings of the sea-coast. I advise you also to exercise the greatest caution in sending to the seashore young girls subject to *ovarian pain* and *dysmenorrhœa*. Sea-bathing is apt to provoke congestion and increased pains in the pelvic organs.—*Med. and Surg. Reporter*.

Nocturnal Incontinence of Children.

Prof. S. P. GROSS, of Phila., advises:

R. Strychniæ, gr. j.; pulv. canthar., grs. ij.; morph. sulph., grs. jss.; ferri. pulv., grs. xx.

M. Make 40 or 50 pills or powders, *pro re nata*. Sig.—One three times a day to a child ten years old.—*Can. Lancet*.

The Treatment of Fever.

Dr. R. FØRSTER (*Jahrb. f. Kindkde.*, XVI. B., 3 u. 4 H.).—The three principal remedies to combat fever in childhood are cold or cool water, quinine, and salicylic acid. F. places the cool water at the head of the list. He finds that even from baths of the same temperature as the body we can in young children obtain a considerable lowering of temperature, while from the colder baths we obtain much greater effect than in adults on account of the greater extent of surface in children as compared with their weight. In a feverish child, therefore, the daily baths are not to be stopped. We may also give cool or cold baths of 12–17° R. (52–60° F.), of 10–15 minutes' duration and repeated three times a day if necessary. The cold pack may be used where the bath is contraindicated by weakness, the presence of wounds, etc. These are the best means at our control to combat fever. In long continued high temperature, however, they must be supplemented by means that have a more lasting effect. These are quinine and salicylic acid.

One reason that these are not more generally successful is that the doses for children are not well enough established, and as a rule too small a dose is given. Hagenbach has arranged a series of doses, but the author has found them a trifle high. Perhaps the golden mean would fall between the two reckonings, which are in grammes as follows:

| FORSTER. | | | HAGENBACH. | | |
|----------|--------------------------|----------------------------------------------|------------|----------------------|----------------------------------------------|
| Year. | Quinine given in 1 dose. | Salicylate of soda in 2 doses 3 hours apart. | Year. | Quinine in one dose. | Salicylate of soda in 2 doses 3 hours apart. |
| 0-1 | ? | ? | 0-1 | | 1.0 |
| 1-2 | 0.4-0.8 | 1.0-2.0 | 1-2 | 0.7-1.0 | 1.5-2.0 |
| 2-6 | 0.5-1.0 | 1.5-3.5 | 3-5 | 1.0 | 2.5-3.0 |
| 6-10 | 0.6-1.25 | 2.0-4.0 | 6-10 | 1.0-1.5 | 3.5-4.0 |
| 10-14 | 0.75-1.5 | 3.0-5.0 | 11-15 | 1.5-2.0 | 4.0-5.5 |

The author finds it best to give the quinine in one undivided dose, both because he gets a better effect from it, and also because of its unpleasant taste. The dose of the salicylate necessary to produce a lowering of the temperature equal to the quinine is so large that if it is given at once we may have unpleasant symptoms of nausea and collapse. It is better, therefore, to give it in divided doses, 2 or 3 hours apart. He never uses it in cases where there is great cardiac weakness, or tendency to cardiac paralysis, as in diphtheria. With these three means, the author claims that we can in all cases cut down a high temperature.—*Amer. Jour. of Obstetrics*, vol. xiv., No. 4.

OBSTETRICS.

Pregnancy and Caries of the Teeth.

During pregnancy many women suffer from caries of the teeth and dental neuralgia. The calcareous salts required for the development of the fetal skeleton must be supplied by means of an increased ingestion of these materials on the part of the mother; in default of this augmented consumption, the nutrition of the maternal bony tissues is

affected and dental caries result. Many pregnant women have a morbid appetite for calcareous and other mineral substances. Preparations of calcium, especially the phosphate and hypophosphite, should in view of the facts mentioned, be administered to enceinte females suffering from the above dental troubles.—*Gazz. delle Clinique*.

A Complicated Twin Delivery.

R. B. BURTON, A.M. M.D.

(*Am. Jour. of Obstetrics*.)

Mrs. S., a primipara eight months advanced in pregnancy, was taken in labor about five o'clock in the morning. But little progress was made until one o'clock on the following morning, when I found the os considerably dilated and the head presenting so far as the protruding and tense membranes permitted me to determine. In the hope of expediting labor, I ruptured the membranes and about a quart of fluid escaped. Palpation now revealed to me the presence of twins. A vaginal examination a few minutes later showed the umbilical cord prolapsed into the vagina and the fetal head still enclosed in membranes presenting at the os. After an ineffectual attempt to replace the pulsating cord, I ruptured the membranes again, and as the head at once descended and pressed on the cord, applied the forceps, and rapidly extracted a living child in an L. O. A. position. Only about two ounces of fluid escaped at this rupture. After detaching the child I made an examination, and found to my great surprise that the prolapsed cord belonged to the remaining twin, as also did the membranes first ruptured. As this child also presented with the head, I at once extracted it with the forceps, but the child was dead. The children were both males, and weighed six pounds each. The placenta was expelled in the

usual way, and appeared to consist of two placentæ joined in the centre, rather than to be one single organ. There were two amnia and one common chorion.

I am in doubt as to whether the head first presenting belonged to the child whose cord prolapsed, and whether the head receded after the rupture of its membranes; or whether the unusual arrangement of the two ovisacs existed by which both sacs presented at the external os at the same time, the amniotic septum between the two cavities traversing the external os somewhat to the right of the median line. I am inclined to the latter view, as it is rather im-

probable that the head of the child in sac A (first ruptured) should have receded when once it was so low down and have made room for the other head. There certainly was nothing like an interference between the two heads and no appreciable cause for such a recession. I can merely suppose that the two membranous sacs presented at the os simultaneously, the one containing the head of the child first delivered (that is, the sac ruptured second) being at the left of the pelvic brim and larger part of the inlet, the other presenting with a small segment on the right side. In rupturing the membranes the first time I presume I

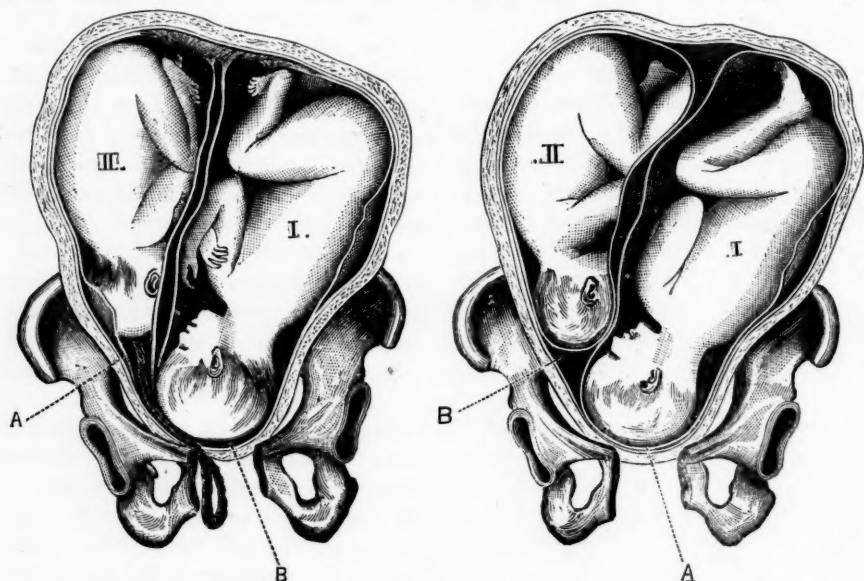


FIG. 1.—A. Membrane ruptured first. I. Child born first. B. Membrane ruptured last. II. Child born last.
FIG. 2.—A. Membrane ruptured first. I. Child born first. B. Membrane ruptured last. II. Child born last.

accidentally opened the smaller sac on the right side, and thus gave exit to the waters of that sac, which washed out the cord of child II., but the head of child I. (in sac B) being originally lower down, at once descended into the pelvic cavity, and being taken by me for the head of the child with the prolapsed cord, was extracted with forceps in order to save its life.

I have not been able to find a similar anomalous presentation of twin ovisacs recorded in the text-books or medical literature. The accompanying diagram may illustrate the condition as I originally supposed it to be, and I have added a drawing to show the ordinary arrangement of the ovisacs in twin pregnancies. A comparison between the two sketches will at once explain my theory.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Treatment of Wounds in Gynecology.

Prof. A. J. C. SKENE, M. D. (*proceedings of Kings County Society*).

While much progress has been made in the management of wounds of the female sexual organs, especially in late years, it remains a question whether this branch of surgery has attained that degree of perfection which distinguishes some other departments of our science and art. It is even doubtful if wounds of the pelvic organ can ever be treated with a like facility and success as the same conditions elsewhere located.

The reason of this is, that owing to the position of the wounds in question, it is difficult to fully employ antiseptic surgery in their treatment. Much has been accomplished in this respect, it is true, but there are difficulties in the way of employing all the means of modern surgery in the practice of gynecology.

Success, in treating wounds of the sexual organs of women depends to some extent upon our ability to employ the means now considered necessary to the healing of wounds in general.

The following may be given as the conditions necessary for the healing of the wounds in question.

A condition of the wounded tissues and of the general system favorable to the repair of injuries :

Perfect coaptation and retention of the parts to be united, and protection of the parts from extrinsic and offending agents during and after coaptation. The management of wounds is not a matter of blind chance. The process of repair in living tissues is governed by definite

laws which are always the same under identical circumstances. To obtain the conditions necessary to the fulfilment of these laws is often difficult and sometimes impossible ; still, the nearer we come to all the requirements the more surely will the desired ends be accomplished.

First, good general health may be found wanting in many ways and degrees, as preoccupation of the system by some highly taxing function, like lactation for example, and certain deranged states of the nervous system.

These certainly have an important bearing upon the healing of wounds. In fact, there is good reason for believing that enfeebled states of the nervous system have much to do with retarding the healing of wounds, even where the general nutrition appears to be normal. Regarding the unfavorable conditions of the tissues generally met with, the following are the most important : First contusions accompanying wounds caused by parturition.

Lacerated wounds of the pelvic organs often heal promptly if well coaptated immediately after they occur, but no such union should be expected in case the tissues are greatly contused. While this is true of the immediate treatment of wounds sustained during labor, it is pretty definitely settled that operation wounds made during the process of involution, that is, within four or six months after confinement, often fail to unite. From this we learn that while tissues are undergoing involution they are not in the best condition to heal ; and also that when involution is delayed beyond the usual time, treatment should

be employed to complete the process before undertaking plastic operations.

Scrupulous care is also required in preparing the tissues by making clean, accurate incisions which will give smooth surfaces to the parts to be united. Old scar tissue should also be excluded from all wounds where union by first intention is desired.

The management of bleeding vessels in these operation wounds is of great importance. All hemorrhage should be arrested before bringing the parts together, because a slight oozing, which would do no harm in a wound to be treated by open dressing, may prevent union in wounds in which drainage should not be employed, or at least should not necessarily be required.

The means used to arrest hemorrhage should be such as will not interfere with the process of healing. Hitherto they have been torsion of the large vessels, and for minor bleedings the use of ice or cold water. More recent experience has pointed out objections to these means. Chilling the tissues by cold is injurious. It has fortunately been found that hot water is more efficient in controlling hemorrhage, and its effects upon the tissues not unfavorable, hence its use as a styptic in these operation wounds is strongly commended. Torsion is also objectionable, because it is less certain to control bleeding than the ligature, and quite as liable to give rise to suppuration. In view of this fact, it may be said, without doubt, that the antiseptic ligature is the best means of controlling the vessels in these wounds. Regarding the material to be used as a ligature, it may be said that that which can be enclosed in the wound without giving subsequent trouble, is the thing required. Some recent experience indicates that Japanese ligature, made of whale sinew, is the best,

owing to its being absorbed with great facility.

The coaptation of the tissues by means of sutures requires more than a passing notice.

To-day we know that it matters little whether silver wire or well-prepared silk sutures are used, provided they are properly introduced. The parts to be united should be brought together and held there without any straining upon the sutures. It is equally important to introduce the sutures so that they will prevent the incurving of the undenuded edges of the parts to be united, and finally, a sufficient number of sutures should be employed to secure uniform retaining pressure at all parts of the wound.

The management of these wounds during the healing process differs somewhat from the modern treatment of wounds in general.

Great harm is often done by the douche of carbolic acid and water, in washing away the exudate which is the natural means of protecting wounds, and is therefore an important factor in the healing process. On this account the use of the douche is especially objectionable during the first forty-eight hours after an operation.

In treating operation wounds of the cervix uteri, an antiseptic dressing can be used in the form of a tampon of borated cotton or marine lint, the latter being preferable, perhaps. By this means the uterus is supported and undue tension upon the sutures, from the movements of the patient in bed, or more especially in vomiting after the anæsthetic, is thereby prevented. More than that, the serum which oozes from the wound is promptly absorbed by the tampon and is disinfected, and the parts are protected from the acid secretions of the vagina. The tampon, applied

immediately after the operation, may be left in place for forty-eight hours, and then if the parts are healing well no further treatment is necessary. If, however, there is undue inflammatory action and signs of commencing suppuration, the tampon should be reapplied and changed every twenty-four hours, until the recovery is completed.

In treating wounds of the perinæum, there are many perplexing difficulties in the way of obtaining a proper antiseptic dressing.

In all operations for repairing old injuries of the perinæum, it is better to *first cure* all uterine and vaginal diseases which give rise to abnormal discharges. This, of course, cannot be accomplished in the treatment of lacerations immediately after confinement. Then it becomes a very important question how to protect the perinæal wound from the lochia. Various means have been suggested, such as coating the vaginal surface of the wound with collodion, placing carbolized lint or borated cotton upon the inner portion of the wound, and, the most common of all, the frequent use of vaginal injections. It is hardly possible to say, at the present time, which is best. The collodion has not been tried often enough to speak positively regarding it. In using the lint or cotton, there is danger of separating the edges of the wound, the very thing of all others to be avoided.

Perhaps the best treatment is to let the wound alone for about two days, trusting that during that time it may become sufficiently protected, by a coating of fresh blood and lymph, to resist the subsequent discharges. After the lochia begins to decompose, the frequent use of the vaginal douche is advisable, and should be continued until the union is completed.

In the operation for restoring the pe-

rinæum, the vaginal portion of the wound may generally be left alone. It is protected from the air by the anterior vaginal wall, which makes a suitable dressing, providing the uterus and vagina are in a normal condition, as they should be, before the operation is made. If suppuration takes place and pus is discharged into the vagina, it should be disposed of by injections. The outer portion of the wound may also be left without dressing, but it is better to apply lint or cotton upon each side of the sutures; if silver wire is used, or if silk is employed, the lint can be placed over the wound, and retained in place by keeping the limbs together. The advantage of this kind of dressing is that it absorbs any discharge that there may be.

Perhaps the most important point of all in the management of such cases is, to keep from spilling urine upon the wound. The most scrupulous care should be taken to close the end of the catheter in withdrawing it. If this is neglected a few drops of urine will escape from the eye of the instrument, and falling upon the wound will cause trouble.

Notwithstanding all this care, suppuration will sometimes occur, and then the question arises, how to manage this complication. If the suppuration is limited to the track of one suture, that one may be removed and the remaining ones trusted to keep the parts together. It sometimes happens that a cellulitis, which begins in the region of the sutures, extends outwards, and ends in suppuration. This should be treated by a free incision and drainage, which may save the operation. On the other hand, if suppuration takes place between the surfaces to be united, there is very little hope of obtaining union at all by any kind of treatment.

A partial or even a complete success

may be obtained in such cases if the suppurative process is detected early, and drainage from the lower edge of the wound is established. This can be effected by loosening one or more of the sutures, and then introducing carbolized silk thread or horsehair to secure the free escape of the inflammatory products.

Anal Fistulæ in Women.

Prof. A. J. C. SKENE, M.D. (*Chicago Med. Review*), after citing several unsuccessful cases occurring in his own practice and that of others, treated with *elastic ligature, incision, etc.*, the author says:

"That the power of the sphincter ani muscle is lost in a large number of cases after operation, is, I believe, a fact. I might go farther than this, and say that, in all cases in which the fistula is located completely outside of the muscle, and it is, therefore, necessary to divide the sphincter in operating, there is great danger that it will not be fully restored. The divided muscle retracts and the space between its ends is filled in very slowly with new tissue; as a result there is usually a large amount of scar-tissue necessary to connect the two ends together. This must impair its functions, if it does not entirely destroy it. In a healthy subject in whom the termination of the fistula does not extend far outward, and the induration of the tissues around the canal is not extensive, the healing process may go on rapidly, thus connecting the ends of the muscle by means of intervening new tissue. Under such circumstances, the function of the muscle may be retained. On the other hand, if the fistula extends from high up in the rectum to a point some distance outside of the muscle, the operation is almost sure to be a failure. Of course, the greater the amount of tissue be-

tween the rectum and the fistula, the farther will the ends of the muscle be separated by retraction, and the longer will the parts be in healing. In such cases the function of the sphincter is very liable to be impaired. When the fistula is located beneath the mucous membrane only, then a perfect result can always be obtained. Mr. John Gray (*Lancet*) states that operative treatment should be deferred until the walls of the abscess, as well as the consequent fistulous tract, have assumed a condition of health and a disposition to take on a healing process. This is certainly a good rule in surgery, because it secures, as far as possible, the condition necessary to prevent fæcal incontinence. In order to avoid such unfavorable results it was evidently necessary to operate without dividing the sphincter muscle, or, if that were impracticable, to secure union of the divided ends of the muscle with the least possible quantity of intervening new tissue.

In the hope of curing the fistula without dividing the sphincter, the following method was adopted: An incision was made through the skin and lower part of the sinus, large enough to admit two fingers below, and one at the upper end of the wound. The edges of the wound were held apart with retractors, and the opening into the rectum was found and brought into view by passing the finger into the rectum and averting the rectal wall through the wound. The edges of the opening in the rectal wall were then pared with the scissors, and two or more catgut sutures were introduced and tied. The external edges of the wound were kept apart by a pledget of carbolized lint, which was changed every day until the wound healed. The idea was, to first convert a complete fistula into a blind, external one, and then finish the cure by compelling the external sinus to

heal from below, outward. To prevent any strain upon the sutures by distention of the rectum, I paralyzed the sphincter by overdistention and kept the bowels free by saline laxatives. Of two cases treated in this way, one was a success and the other only partially so, as the opening into the rectum closed, but a blind, external fistula remained.

Regarding this method of treating fistulæ, I can only say that the danger of loosing the sphincter muscle is avoided, which is very important, but still there are objections to it. The operation is difficult to perform, at least the closing of the opening in the rectum with sutures is not easy, and then, my impression is, that it will fail to cure some cases.

Dr. Dudley, of Chicago, suggests laying open the fistula, trimming off the indurated tissues along its track and then treating as a *lacerated perinæum*, with sutures.

Elytorrhaphy.

Dr. WALLACE gives his experience with various operations for prolapsus uteri, consisting chiefly of a narrowing of the lower part of the vagina by means of longitudinal anterior (or anterior and posterior) elytorrhaphy, more or less modified, according to the nature of the case, and associated with the operation for lacerated cervix, with fixation of the cervix to the anterior wall of the vagina, and with restoration of the perinæum. (His results have been very encouraging, although some of the cases reported offered little promise of success. Of the various procedures described, the one that seems most of a novelty is that of fixing the cervix to the anterior vaginal wall. Taking advantage of a large erosion of the anterior surface of the vaginal portion of the cervix, the latter was stitched to

a raw area produced by dissecting up a flap of mucous membrane from the anterior wall of the vagina. It seems to us that this must give rise to a marked and permanent retroversion, and, in the absence of cystocele and with a sound perinæum, thus guard against procidentia by the mere fact that the uterus is unable to present at the vaginal outlet by its short diameter. Such a retroversion of the uterus is not likely of itself to give trouble in a patient past the menopause, and, as the author remarks of versions in general, may not even in younger subjects.)—*Canadian Jour. of Medical Science.*

Excision of a Gravid Cancerous Uterus.

The total excision of a gravid cancerous uterus was accomplished for the first time in England by Mr. Spencer Wells, on Friday, Oct. 21st. This operation is a combination of Freund's excision of the entire cancerous uterus, and Porro's addition to the Cæsarean section of supra-vaginal amputation of the uterus. The patient was thirty-seven years of age, mother of five children, in the sixth month of pregnancy, and suffering from epithelioma of the cervix. This specimen is now at the College of Surgeons, and will form an important addition to the museum.—*London Lancet.*

Bursting Cysts of the Abdomen.

Dr. WM. GOODELL (*Amer. Jour. of Obstet.*): He made special reference to cysts which, of their own accord, burst and refilled. Illustrative cases were given: first, that of a patient who had an abdominal tumor from which she was greatly oppressed with a bursting sensation. It was aspirated, and eight quarts of blood-stained fluid were withdrawn. It was subsequently aspirated, and the fluid withdrawn was of a greenish color.

He regarded it as a monocyst of the right ovary. Subsequently a day was appointed for aspiration, but before the operation was performed the cyst burst spontaneously. On four occasions it burst spontaneously, and was tapped probably about a dozen times. Finally the condition of the patient became such as to render the removal of the tumor necessary. The cyst-wall was found to be exceedingly thin and of a beautiful conjunctival blue color. The tumor was ostensibly that of cystic degeneration of the ovary, but, upon more careful examination after its removal, it was proven to be ovarian and parovarian. A second case was reported in which what was supposed to be an ovarian cyst burst, and the patient remained cured for nineteen months. At an operation subsequently performed it was found that the cyst-wall was very thin, and that it contained a turbid fluid, and that it was extra-ovarian. He therefore regarded it as a bursting cyst of the parovarium. The author then gave some statistics of the greater mortality of bursting ovarian cysts. A collection of ninety-seven cases was cited in which there were forty-six deaths and fifty-one recoveries. When, however, parovarian cysts ruptured, the fluid was so bland that fatal results did not usually occur. He had been able to find the record of only one fatal case. While tapping may cure parovarian cysts, spontaneous rupture does not always terminate so, for the cyst is apt to refill. He had tapped in five cases, the fluid was clear like spring water, and in none had the cyst refilled. Cysts of the parovarium are almost always unilocular. They may be bilocular or multilocular, but the latter are very rare. It is questionable whether a true unilocular cyst of the ovary has ever existed. The parovarian cyst is usually slow in development as

compared with ovarian cysts. Some of them develop a remarkable disposition to remain stationary; and one peculiarity of stationary cysts is that they are frequently in a flaccid condition; that is, they exhibit varying degrees of distention according as the quantity of fluid which they contain changes at different times. Such variations in distention he had not seen in connection with ovarian cysts.

Non-Specific Urethritis in the Female.

Dr. M. J. LEWIS (*Med. Annals*): Mrs. H., aged 38, married six months. I was summoned, found her in great pain. The day previous to my visit, she felt a burning sensation in voiding urine, which was aggravated during the night to such an extent as to banish sleep. An examination showed the pulse to be 108; temperature, 102 $\frac{3}{4}$. The labia were normal, as were also the walls of the vagina, excepting within a few lines of the urethra, which, through the vaginal walls, felt like a whip-cord, hard and painful to the touch. The pain extended along the urinary tract as far up as the kidneys on both sides. Pressure along the urethra as far as the meatus showed no signs of pus, nor any other than a slight mucous discharge. The meatus was red and angry looking. The patient had her menses twelve days previous to the first signs of her present ailment, and had not cohabited since that time. There was no leucorrhœa. The patient could assign no reason for this sudden attack, excepting that she had been out on a rainy day five days before, and upon coming home felt chilly. An ordinary ear-speculum was introduced in the urethra, and as far as could be seen, the canal was in the first stages of inflammation. A flexible catheter, dipped in a salve of carbolic acid and vaseline, was next introduced, and

created great pain whilst traversing the first inch of the tract, when it passed more easily on towards and into the bladder. The urine, as it passed through the catheter, was collected in a vessel, and the after examination showed it to have a slight excess of phosphates; decomposition commenced very soon after. Holding the index finger of the right hand against the urethra, as far back in the vagina as possible, injections of warm water were made with a small glass syringe. The patient was ordered to remain in a recumbent position—a teaspoonful of rochelle salts to be taken every hour until a free evacuation from the bowels was effected. Mucilaginous drinks were prescribed, and vaginal injections of warm water every hour. A dessertspoonful of liquor ammonii acetatis was taken at 7 P. M. The following morning the patient felt greatly relieved, and three days after the manifestation of the primary symptoms the urethritis had subsided. At no time was there a purulent discharge.

[It is doubtful if such an affliction as the above should be called urethritis. We can hardly imagine an inflammation of the urethra running its course in three days without any purulent discharge. More than likely it was spasmodic not inflammatory]—A. J. C. S.

A Point in the Diagnosis of Ovarian Tumors.

By Dr. SLAVJANSKY, *Russia (Int. Med. Congress)*. The author directed attention to a symptom enabling the diagnosis of the side from which an ovarian tumor might spring to be made out more clearly than usual. It is, that if the sensibility of the two sides be compared, it will be found that it is less acute on the side of the affected ovary. He then gave five cases which had been operated on, in all of which the side

from which the diseased ovary had grown had been correctly made out by the impaired sensibility discovered on that side in the inguinal region. He could not explain the symptom.—*Centralbl. für Gyn.*

Chlorhydric Acid in Chlorosis.

Dr. ZANDER, in the *Centralblatt für die Med. Wissenschaften*, contests the exactitude of the widely spread opinion that chlorosis is due primarily to an alimentation containing too small a proportion of iron. The malady is induced by default in the absorption of iron introduced with the food, because the gastric juices do not contain a sufficient proportion of chlorhydric acid. The result is that the albuminoid principles are incompletely digested, and nutrition languishes.

With this view of the question, the author has had recourse, in the treatment of chlorosis, to the following solution:—

R. Acid. chlorhydric, 2 to 4 grams;
Aqua destill., 200 grams. M.

One or two tablespoonfuls of this solution may be taken after meals, and in obstinate cases pepsin may be added.

This treatment has, in the experience of Dr. Zander, given good results.—*Med. and Surg. Reporter.*

Anteflexion and Dysmenorrhœa.

Dr. HERMANN, of London: The purport of the paper was summarized in the following propositions: 1. There is no anatomical evidence that anteflexion causes any hindrance to the escape of menstrual fluid. 2. There is reason to think that well-marked anteflexion is present in nearly half of all women who have not borne children. 3. Therefore it is to be expected that anteflexion and dysmenorrhœa would frequently coin-

cide. 4. Dysmenorrhœa is, practically, as common when the uterus is straight as when it is anteфлекed. 5. Painless menstruation is, practically, as common when the uterus is anteфлекed as when it is not. 6. When dysmenorrhœa and flexion go together, the severity of the pain bears no relation to the degree of the bending. 7. Dysmenorrhœa associated with anteфлекion, is frequently cured without straightening the uterus. 8. There is no evidence that straightening the uterus invariably or even frequently removes dysmenorrhœa which is associated with anteфлекion, and in which other methods of cure have been ineffectual. 9. These facts show that the relation between anteфлекion and dysmenorrhœa is not that of cause and effect, but merely that of coincidence.—*Ibid.*

[Notwithstanding the above statements gynecologists know that there is a form of dysmenorrhœa associated with flexion of the body and cervix uteri, which is relieved by curing the flexion. There are also many other causes of dysmenorrhœa than flexion of the uterus. This fact takes from the value of Dr. Hermann's propositions.] — A. J. C. S.

Liniment in Prolapse of the Uterus.

In prolapse of the uterus, M. CHERON, of the St. Lazare Hospital, besides the application of a pessary to keep the organs in position, prescribes the following liniment, in order to ease the neuralgic pain from which many patients suffer; chloroform, 3 iij.; ether, 3 iv.; camphorated spirits, 3 iij. These frictions on the lumbo-sacral region are attended with the best results. Also, to restore the tone to relaxed ligaments, he gives: bromide of potassium, 3 iss.; tincture of iodine, gtt. xv.; tincture of aconite, gtt. xxiv.; syrup of tolu, 3 x. A teaspoonful before each meal.—*Medical Press and Circular.*

Premature Menstruation.

Dr. PROCHOWNICK (*Med. & Surg. Reporter*), of Hamburg, stated that a district physician had called his attention to a child three years of age, highly scrofulous, who, since one year ago, was subject to regular catamenial discharges, lasting from two to three days, every four weeks.

This child died of miliary tuberculosis two days after such a flow, and an autopsy was made twenty hours later. The uterus was not large, but its mucous membrane had every appearance of being *post menses*. Its size, thickness, dimensions, and the proportions between the neck and body, far exceeded those usual in the uterus of a child of that age.

It is interesting, therefore, to observe that this menstruation was incidental to a regular evolution of the ovules.

This case is important, because it shows the primitive relation which must exist between menstruation and ovulation. [We infer that the ovaries gave evidence of repeated ovulation although that is not stated, otherwise we fail to see how "this menstruation was incidental to a regular evolution of the ovules."] — A. J. C. S.

DISEASES OF CHILDREN.

Diphtheritic Group.

Dr. J. W. BATTEN, Pittsburgh, Pa., (*Louisville Med. Journ.*). I saw James H. W., aged 6 years, on November 2d, 1880. He had been sick about a week, with what the mother stated was a bad cold. Upon examination, the throat was red, with a patch of membrane behind each tonsil; the tonsils were not very much enlarged, the sub-maxillary glands were slightly enlarged, the tongue was coated, the breathing was labored and abnormal; there was aphonia; the

cough was dry and had a ringing, whistling sound; the patient had been restless the previous night. I put the child on No. 1:

R. Bromid. potass., gr. l.; chlorat. potas., gr. l.; tinct. aconiti rad., gtt. xij.; syr. tolutani, syr. senegæ, aa, ʒ ij.; aquæ, ʒ ss. M. Sig.—A teaspoonful every three hours.

The following day the symptoms, if anything, were more grave; the child had perspired freely after having been placed in bed, in a warm, comfortable room. The eyes were glassy and ejected, breathing difficult, head thrown back; countenance anxious, pulse 110 to 120, respirations frequent; a dry mucous râle in both bronchia. The case was not one favorable for tracheotomy, for the membrane ramified the trachea and bronchia and bronchial tubes of both lungs. I continued the treatment till evening, with the addition of inhalation of lime steam, when I put the patient upon No. 2:

R. Chloratis potass., gr. lxxx; tinct. ferri chlor., gtt. clx; syr. simplicis, ʒ ss.; aquæ, ʒ iss. M. Sig.—A teaspoonful every three hours, and withdrew the first prescription.

I kept the patient on this until Friday morning, November 5th, with inhalation of steam from lime. There was no improvement; the father stated to me that the patient could not swallow the medicine during the previous night. I then put him on No. 3:

R. Hydrarg. chlor. mit., gr. iv.; pulv. ipecac., gr. ij.; albi sacch., gr. xx. M. Ft. chart. viij. Sig.—One powder every three hours.

I told the father to give the second prescription as often as possible. In the afternoon the patient commenced expectorating a thick, tenacious, muco-purulent matter, a half-pint in quantity; after this the patient commenced to breathe

easily, the cough became hoarse, expectoration easy, and he went to sleep for the first time since the night of November 1st (Monday night). The patient is now rapidly convalescing; has not regained his voice. During the little patient's sickness I gave whisky and nourishing diet freely. On examining the urine, November 7th, I found it loaded with albumen.

Anthelmintic.

R. Santonini, gr. ij.—vj.; sacchari lactis, gr. x.

M. Make a powder to be taken early in the morning, suspended in a tablespoonful of cream. The patient ought to have fasted twelve hours previously. The dose may be repeated daily for eight or ten days, if necessary, and its exhibition should be followed at the end of six hours by the administration of one or two teaspoonfuls of the compound decoction of aloes. The eighth or sixth of a grain of the resin of podophyllum added occasionally to the dose of santonin appears to increase its efficacy. The friends of the patient should be warned that after a few days the sight sometimes becomes perverted, so that objects seem to acquire a blue or yellow or some other color. This is specific for *ascaris lumbricoides*.—*Med. Gazette*.

Destruction of Tape-Worms.

For the destruction of tape-worms the following is specific:

R. Ext. filicis liquidi, ℥. x.—xx.; syrupi zingiberis, fl ʒ ss.—j.; mucilag. tragacanthæ, fl ʒ j.—ij.; aquæ, fl ʒ j.—ij.

M. Make a draught. For a child five to ten years old. To be taken early in the morning, only liquid nourishment having been allowed the day before. Four hours afterwards a purgative dose of castor oil or compound decoction of aloes should be administered.—*Ibid*.

Santonine Against Ascarides.

The medication par excellence against ascarides, and which has dethroned other forms of treatment, is that by the glucoside of semen as against santonine, which is constant in its effects, tasteless, and active in small doses.

It was discovered in Germany as recently as 1830. At the dose of three to eight grains it induces xanthopsia, and a reddish coloration of the urine, but expels the worms completely, and without pain. M. Baylet (*Revue de Thérap. Méd. Chirurgicale*) recommends the following prescriptions:—

1. For a child under three years:

℞. Santonin, gr. iij; calomel, gr. iij.
M.

Et divid. in chart. No. viij.

2. Children from three to twelve years:

℞. Santonin, gr. iij.; calomel, gr. vj.
M.

For eight powders.

3. For an adult:

℞. Santonin, gr. vj.; calomel, gr. ij.; Jalap pulv., gr. iij. M.

For eight powders.

SIG.—One of the powders to be taken each morning in honey. On the fourth day, a laxative, preferably castor oil, should be taken.—*Med. and Surg. Reporter*.

Cure of Spina Bifida with Iodine Solution.

The Glasgow *Medical Journal* gives this case in a recent issue:

The patient was an infant a month old. The cleft in the spine appears to be in the lower lumbar or upper sacral region. The tumor was almost as large as an infant's head, and was quite translucent, except a small portion at the base, where it was opaque; the skin evidently was thinned from distention, but the surface was quite sound. There

was a slight longitudinal furrow, but there was no evidence of any septum. On May 25th chloroform was administered, about one-half of the fluid within the tumor drawn off, and solution of iodine injected, according to the method devised and practiced by Dr. Morton, of Glasgow. The tumor slowly filled again, and within a day or two reached almost its former size. The skin, however, appeared to thicken, and gradually the tumor lessened in size, so that in the course of a few days all that remained of the tumor was a small nodule of thickened and puckered tissue at the site of the puncture, and some redundant skin altering to some extent the outline of the buttock. The injecting of the tumor had no appreciable effect on the health of the child. When last seen, on August 22d, there was no tendency whatever to a return of the tumor and the child was in good health.

Nervous Diarrhœa in Children.

Dr. WILLIAM LEE (*Maryland Medical Journal*) reports a case of the above affection where palpitation of the heart was a prominent symptom, in which the following were given with prompt relief:

℞. Bromid. potass., 3 ijss.—10.00 gm.; elix. val. ammon., 3 iv.—16.00 fl. gm.; aquæ, 3 iij.—93.00 fl. gm.

S.—Teaspoonful in water between meals.

℞. Tinct. ferri chloridi, gtt. lxxx.—2.50 fl. gm.; tinct. digitalis, gtt. xxxvj.—1.11 fl. gm.; strychniæ, gr. ¼—0.016 fl. gm.; elix. adjuvant, 3 iij.—88.67 fl. gm.

M. S.—Teaspoonful every four hours in water.

Capacity of Hearing in Children.

An examination of four thousand five hundred children in Stuttgart and its

environs led to the following results : (1) A normal ear hears a whisper of medium intensity at a distance of twenty to twenty-five metres, when the surroundings are quiet ; (2) Disturbances of hearing are uncommonly prevalent among the young—in the public schools as many as thirty per cent. of the scholars hear quite poorly with one or both ears, while a still larger percentage do not hear perfectly ; (3) Among the poor we encounter defective audition more frequently than among the better classes ; (4) The percentage of disturbances of hearing increases with age ; (5) In country schools the conditions are comparatively better. Many of the affected children were not at all aware of their infirmity.—*Med. Correspondenzblatt*.

Cholera Infantum.

Dr. M. H. JACKSON (*Southern Pract.*) This disease prevails to some extent every summer in this locality, and is a source of no little annoyance and trouble to the general practitioner. I beg leave to suggest the following formula, which has frequently proved beneficial in my hands, and with which I am well pleased:

℞. Bismuth. sub. nit., grs. v. to x.; calomel, grs. $\frac{1}{8}$ to $\frac{1}{4}$; ingluvin, creta præp. aa, grs. ij. to iij.

S.—Take every two hours.

Resorcin in Cholera Infantum.

In Breslau ninety-one cases of cholera infantum were treated with resorcin in the dose of one-third to one-half grain in two ounces of infusion of chamomile. The success of this treatment was remarkable. How often the dose was given is not stated.—*New England Med. Monthly*.

Treatment of Hydrocele in Children.

DEFERT's method of obtaining a radical cure in ordinary hydrocele, consists in evacuating the greater part of

the contents of the sac through a trocar and then introducing, through the latter a director coated with melted nitrate of silver, with which he touches numerous points on the internal surface of the tunica vaginalis. A certain amount of the nitrate also dissolves in the residual fluid and mildly cauterizes the whole of the internal surface of the sac. The director and canula are then withdrawn. The director is charged by depositing powdered nitrate of silver in the end of the groove for a distance of 2 ctm., and melting it slowly over the flame of an alcohol-lamp in such a way that the caustic shall project slightly beyond the surface and tip of the director.—*Med.-Chirurg. Rundschau*, August, 1881.

Treatment of Ophthalmia Neonatorum and Purulent Conjunctivitis.

Dr. WOLFE's procedure is as follows :

1. When seen in the first stage, before the purulent discharge has set in, the patient's head is placed on a towel and secured on the doctor's knees. The lids are then everted, singly or together, and, after cleaning them with dry lint, he touches the conjunctival surface with lint dipped in this solution :

℞. Boracis, gr. x.; aq. rosæ, f 3 j.; aquæ ad f 3 vj.—M.

One dessertspoonful in two ounces of warm water.

He then puts a few drops of the solution of atropin upon the conjunctival surface :

℞. Atropiæ sulph., gr. j.; aquæ, f 3 ij.; glycerinæ, f 3 ss. M.

The application is repeated three times a day. The atropin has an anti-phlogistic effect upon the inflamed surface, and also, by dilating the pupil, relieves the tension of the eyeball. Dr. Wolfe never uses cold applications, nor does he employ ointments to keep the lashes from sticking together ; washing

with warm water is better. Dry lint is then applied to the lids and secured by an immovable bandage. The case is watched carefully.

2. When the case is found to be unmistakably one of purulent ophthalmia, the lids are everted one after another, dried as before; a few drops of the solution of atropin dropped in, the surfaces touched with a stick of argenti nit. two parts, potass. nit. one part, and a few more drops of atropin put upon the cauterized surface. When the conjunctival surface is bleeding (a favorable symptom, it is dried with lint and the cauterization repeated. The whole conjunctiva is touched, and also the *cul-de-sac*. He bathes it with lint and warm water, and covers the eyes with dry lint and a bandage. If one eye only is affected, the other is closed with court-plaster and covered with lint.

3. When called to see a case in the stage of advanced suppuration, say of three or four weeks' standing, the eyelids must be opened with great care, as the eyeball may be ruptured. If the cornea is found intact, the atropin and nitrate of silver pencil are to be used.

4. When an ulcer of the cornea or an abscess has already formed, it is the more urgent to use the nitrate as the only weapon to combat the disease. When the cornea is not actually ruptured, Dr. Wolfe generally manages to arrest the progress of the disease, and save it even if it is found in the process of softening or with an abscess. Such cases should be seen daily. In public hospitals or dispensaries Sundays must not be excepted, for one day's neglect may prove disastrous.—*Cin. Med. Rec.*

Aphthous Sore Mouth of Infants.

Prof. WALLACE believes that the sodium sulphite solution is the best remedy for aphthous sore mouth in infants.

R. Sodii sulphit., gr., xxx.; glycerini, aquæ, aa $\frac{3}{4}$ ss. M.

To be used on a swab every two hours. Where the child is using a nursing bottle, scrupulous cleanliness is required. The rubber nipple should be turned inside out after each time of using, washed clean, and placed in a solution of bicarbonate of sodium (baking soda), in a tumbler, until again needed. It is better to have two, and use them alternately. Milk must never be allowed to stand in the nursing bottle until it becomes sour.—*College and Clinical Record*, Vol. ii., No. 2.

Thumb-Sucking.

Dr. GOODWILLIE of New York City, at American Medical Association, reported a case and illustrated it by a wax model. The treatment consisted in breaking up the habit by applying a leather pad to the elbow, preventing the hand from coming to the mouth; and nasal catarrh is to be treated by douches and the application of powder blown into the nose, proper food, clothing and rest. His conclusions were as follows:

1. Thumb-sucking is more disastrous to the health of the child than the sucking of the other fingers; for the thumb, once in the mouth, it more readily remains during sleep.

2. It interferes with the child's proper rest, which should be continuous and undisturbed, and so becomes a source of nervous irritation and exhaustion.

3. It interferes with the natural respiration through the nose, and sets up abnormal conditions.

4. It malforms the anterior part of the mouth and affects proper mastication.—*Va. Med. Monthly*.

The Salicylates in Serous Diarrhœa.

The following are Dr. HUTCHINGS formulæ for salicylic acid in the serous diarrhœa of infants:

℞. Acidi salicylici, gr. xxx.; cretæ prep., g. x.; syrupi, 3 ij.; aquæ, 3 xvj. M. Sig. Two teaspoonfuls every two to four hours.—*South. Med. Rec.*

℞. Acidi salicylici, gr. xxvj.; bismuthi terroxiidi, gr. xvj.; tr. hyoscyami, 3 j.; syrupi, 3 ij.; aquæ, 3 xij. M. Sig.—Two teaspoonfuls every two to four hours.—*Ibid.*

℞. Acidi salicylici, gr. xxij.; cretæ perperatæ, gr. viij.; Misce et div. in partes no. vi. cel x. Sig.—One every two to four hours.—*Ibid.*

Summer Diarrhœa of Children.

℞. Bismuth subnitrate, 3 j.; Pepsinæ sach., 3 ss.; zinci oxidi, gr. vj. M. Ft. pulv., No. xij. Sig.—One powder every four to six hours.—*Dr. Bartholow.—Ibid.* Or, ℞. Plumbi acetat., grs. viij.; Acid. acet., gtts. vj.; tinct. opii deod., gtts. iv.; aquæ destill., 3 j. M. Sig. A teaspoonful every two, three or four hours for a child two years of age.—*Dr. Bartholow.—Ibid.*

Summer Dysentery and Diarrhœa of Teething Children.

℞. Ipecacuanhæ, grs. xij.; bismuthi subcarb., 3 j.; pepsinæ sacch., 3 ss. M. Ft. pulv., No. xij. Sig. One in milk every two hours.—*Dr. Bartholow.—Ibid.*

Improved Chalked Mixture for Infantile Diarrhœa.

℞. Prepared chalk, loaf sugar, aa ½ ounce; glycerine, 2 drachms; cinnamon water, 2 ½ ounces; creosote, 3 drops.

Dose, a teaspoonful every three hours. This preparation is more effectual than the old formula, and will not sour by keeping.—*South. Med. Record.*

Gholera Infantum.

℞. Creosote, gtt. j.; lime water, 3 ij. One teaspoonful with a teaspoonful of milk, breast milk if a sucking infant, re-

peated every one to two hours. Useful when vomiting is troublesome.—*Naphey.*

Alcoholic Medication in the Newly Born Infant.

M. JULES SIMON, in a lecture on Alcohol in Infantile Therapeutics, delivered at the "Hospital des Enfants Malades," spoke as follows on its employment in the newly born infant :

A child born in a state of excessive debility has not the strength to live; either it has not arrived at full term, or labor has been long and difficult so that the child comes into the world apparently dead; by artificial respiration signs of life are evoked, but the infant remains so feeble that it is incapable of suckling, and the absence of all nutrition will soon overcome the already precarious vitality. Do not, in such a case, hesitate; have recourse to alcoholic preparations; give to the feeble little mortal every quarter of an hour a teaspoonful of the following mixture, of course with proper precautions to avoid the entrance of the liquid into the larynx: wine of Malaga, one-half ounce in half a glassful of luke-warm water; at the same time the child may be placed in a bath of wine. Under the influence of this treatment the child soon revives and becomes capable of suckling.

But there is one fault to be avoided in practice when alcohol is recommended in such cases. This medication though very active and powerful, under the circumstances I have mentioned, must not be carried too far; and the parents should not be allowed to consider it as a means of bringing up children. It cannot replace suckling.—*Med. & Surg. Reporter.*

OBSTETRICS.

Viburnum and Chloral in the Treatment of Miscarriage.

R. Fl. ext. viburni prun. fol., fl. 3 iv.; 16.00 gm.; chloral hydrat., Div; 5.17 gm.; syrup aurantii cort., ad., 3 ij.; 60.00 gm. M. Sig.—Tablespoonful every two or three hours.

Dr. CULLEN cites a case in which this combination saved a woman from miscarriage at the seventh month, after dilatation of the os had reached a diameter of three-fourths of an inch.

On Shortness of the Cord as a Cause of Obstruction to the Natural Progress of Labor.

Dr. MATTHEWS DUNCAN read this paper before the Obstetrical Society of London. He said the obstruction arose from the morbidly early establishment of a solidarity of or union between the fœtus and the genital passages, in which it should be easily moved. The cord was taut, then stretched, and advance of the fœtus was difficult or impossible without injury. The cord might be absolutely short, or it might be made relatively short by encircling the neck or other parts of the fœtus. Its length when stretched had to be considered as well as that when not stretched. Twelve inches of cord would stretch about two inches before breaking. Most cords would break with gradually applied tension by a weight of about eight pounds. Labor-power, if it breaks the cord, must of course be greater than its tensile strength. When the cord was shortened by encircling the neck its fatal attachment was, so far as delivery is concerned, the neck, not the navel, and the measurement from the placental attachment to the neck was about two inches longer than to the navel; hence a greater length was required in this relative

shortening than in absolute shortening when the measure is to the navel. Disturbance of mechanism rarely occurred until the child was partly born. The cord might then be torn across or the placental end freed by separation of the placenta, or inversion of the uterus might occur, or the fœtus might be born by a kind of spontaneous evolution. In this evolution, taking place after partial birth, the anterior surface of the body was by rotation made to look forward, so as to make the most of the length of the cord. The cord-insertion was the fixed point. The cord was tight, and passed below the lower border of the symphysis between its two insertions. A cord of twelve inches measured to umbilicus, or one of fourteen inches measured to neck, in both cases inclusive of gain by stretching, would permit birth by spontaneous evolution if it was strong enough. A cord measuring under ten inches when stretched would necessitate rupture or cutting of cord, or inversion of uterus, or separation of placenta.

Dr. Barnes was surprised to hear Dr. Duncan describe the cord as sometimes springing from the upper edge of the placenta. Levret had pointed out long ago that the cord, if it sprang from an edge, always sprang from that nearest the os, and he had himself constantly verified this conclusion. He would submit, as a means of lessening the tension of a cord artificially shortened, the method of compressing the uterus downward during the second stage. Instead of losing time in trying to slip the loop over the head or shoulders he had found it better to cut the cord at once.—*Med. Times and Gazette.*

Management of Abortions.

Dr. PARVIN (*The Obstetric Gazette*) presents his manner of meeting the difficulties of these cases. He says: sup-

pose a case of incomplete abortion having hemorrhage which by its persistence of profuseness brings danger to the patient, or commencing offensive discharge that heralds a possible septicæmia, and then interference is imperative and must be immediate. Let the patient lie on her back, upon a hard bed, her hips brought to its edge, lower limbs strongly flexed; then introduce Neugebauer's speculum, and bring the os fairly in view; now catch the anterior lip with a simple tenaculum or, better, with Nott's tenacular forceps, and then if there be any flexion—and it is not uncommon in cases of spontaneous abortion to observe this—use gentle traction to strengthen the bent canal; at any rate fix the uterus by the instrument. Now take a pair of curved polypus forceps of suitable size, or, better still, Emmet's curette forceps, and gently introduce the closed blades into the uterine cavity, open them slightly, then close them and withdraw, when the fragments of membrane can be removed, and the instrument be re-introduced. Repeat this three or four times, if necessary, until all the membranes or placental fragments are extracted. Then, by means of an applicator wrapped with cotton wool, swab out twice, or oftener, the uterus with Churchill's tincture of iodine—one of the best of local uterine hæmostatics, if not one of the best of antiseptics. Finally, let the patient have ten or fifteen grains of quinia, and it will be very rarely, indeed, that her convalescence is not prompt and perfect.

The Effects of some Drugs in Lactation on Nurse or Nursling.

THOS. M. DOLAN, F.R.C.S., Ed. (*Lond. Practitioner*):

CHLORAL, HYDRATE OF.—Fifteen grains of chloral given to a patient every four hours before confinement until

seventy-five grains had been taken. Labor slow, tedious, terminated naturally. No trace on third day in milk. I believe that chloral does have an effect upon milk, though when given before labor it is eliminated before the third day.

CASTOR OIL.—The effects of castor oil in the nursing state are well known. In plethora when the secretion is deficient it is most useful; and the leaves of the plant will be found of great benefit applied as a cataplasm. I have repeatedly given castor oil to mothers, and have invariably found that it exercised a purgative action on the child; the mother's milk possessing the taste and flavor of castor oil.

DIGITALIS PURPUREA, PURPLE FOXGLOVE.—As a rule digitalis lowers vascular activity and blood-pressure, although there are occasions when it has an opposite effect. It is well called a cardiac tonic, as it regulates the heart beats, producing rhythmic contractions in place of disordered and irregular action. As the latter state may exist during lactation, its administration may sometimes be deemed advisable. In three cases I administered infusion of digitalis in half-ounce doses every six hours, but could not detect any evidence of it in the milk. This is doubtless owing to its being so speedily eliminated by the kidneys.

ERGOTIN.—I gave twelve grains to a private patient one month after confinement, owing to a slight attack of hemorrhage, in doses of two grains every three hours; the effect was satisfactory. The mother told me that she believed the pills, though small, had affected her milk, as her child was cross and seemed to suffer from pain, and would not take the breast. She said she would not take any more medicine. She allowed me to draw off some of her milk, which was

submitted to the test but none was found.

IODIDE OF POTASSIUM.—I gave fifteen grains of iodide of potassium every three hours. After she had taken sixty grains I drew off six centimeters of milk and tested it. No alteration as regards quantity of secretion. I continued the iodide for some days in smaller doses (five grains) but still there was no decrease in quantity of secretion. So that my observations do not confirm those of Dr. F. H. Morris, but I believe its prolonged use deteriorates the milk by impoverishing the blood.

I drew off twenty centimeters of this woman's milk on the third day of her taking the iodide, and gave it to a child aged eighteen months. The child's urine was collected and examined; slight traces of the drug found.

OPIUM.—I had a patient, Mrs. H., a lady in good position, who was in the habit of taking the tincture for sleeplessness, her usual dose being twenty to thirty minims. As she was suckling, I asked her whether she had noticed any effect on the child; she answered yes. When the child was fed it slept the whole night without disturbing her. Her infant was pallid and listless. She sent me some of her milk after taking her usual quantity of the tincture. Odor slightly altered. Responded to test for morphia.

QUININE.—Small doses, three grains every hour, were given to Alice W. After twelve grains had been taken eight centimeters of milk were drawn off, but no trace could be found, though it was found in the urine. The child did not object to taking the breast. No doubt only a small quantity was taken up by the blood, as the dose was small; the largest quantity being eliminated by the kidneys.

RHUBARB (*Rheum Palmatum*).—All the polygonaceæ are not so readily ab-

sorbed as this drug. It is almost exceptional as regards the ease with which it can be found in the urine, sweat, in the serum of the blood, and in the milk. It colors the secretions, owing to the presence in it of chrysophanic acid. As a purgative for women and children it is well known. It acts physiologically upon the infant through the agency of the mother's milk, which it renders slightly bitter and at the same time purgative.—*Louisville Med. News.*

Effect of Drugs on Lactation.

The practical conclusions of Dolan and Wood, in *Practitioner*, are:

(1) Therapeutical agents intended to act on the mammary gland must first enter the blood. (2) Drugs derived from the natural orders Liliaceæ, Cruciferaæ, Solanaceæ, Umbelliferaæ, etc., enter the blood and impregnate the milk, hence caution is needed in giving such drugs to nursing women. (3) The only approach to a true galactagogue is jaborandi. (4) Belladonna is an antigalactagogue. (5) In inaction of the mammæ the milk may be increased and influenced by medicines. (6) The milk may be increased in heat-forming elements by administration of fats. (7) The salts of milk are improved by administration of medicines. (8) Various physiological actions—purgative, alterative, diuretic, etc.—are produced in the child by giving drugs to the mother. (9) We must look to diet for improvement in milk-secreting power, both as to the quantity and quality of the milk.—*Ibid.*

Chloral in Incoercible Vomiting.

Dr. DUSSAUD (*Paris Médicale*) mentioned the case of a woman, 28 years old, pregnant, who, at regular monthly intervals, suffered from incoercible vomiting; this was subdued by chloral injections.—*Med. and Surg. Reporter.*

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Laceration of the Cervix.

WM. GOODELL, M. D., of Philadelphia (*Amer. Journ. of Obstetrics*):

In my opinion, the cervix should always be restored whenever ectropion of the mucosa takes place, and whenever the glands of Naboth become enlarged. Indeed, the visible presence of these glands around the os externum is a very good proof of cervical laceration. But it is not an infallible one, for I have met with them in virgins and in multiparæ with hemorrhagic tendencies from fungous vegetations. These glands often honeycomb the line of denudation, and I make it a rule, whenever it is feasible, to dissect them out.

Another indication for the operation is a hereditary tendency to malignant disease. There is no question in my mind that a cancer of the cervix starts from the constantly-fretted and chafed, raw surface of a laceration. One would infer this from *a priori* reasoning; but it is further substantiated by the fact that this disease very rarely, indeed, attacks a virgin or a sterile woman. On the other hand, the more children a woman has given birth to, the greater her liability to cancer. Then again, the fissure of an old rent is very often found in a cervix attacked by malignant disease. Acting upon this belief, I have operated upon torn cervixes, without local or constitutional symptoms, for no other reason than that there was a history of cancer in the family.

A third indication for the repair of the cervix is the existence of stubborn and subacute peri-uterine inflammations.

Every one of us has seen cases of bad cervical laceration complicated with tender and thickened broad-ligaments, or with more or less of fixation of the womb—cases which refuse to yield to treatment. Usually each menstrual period rekindles the dying embers of the inflammation, and these monthly exacerbations undo the good gained by the intermenstrual treatment. In these cases there is plainly a relation of cause and effect between the lower lesion of the cervix and the upper pelvic lesions. The cervical wound produced in the first place the phlegmon of the broad-ligament, and the monthly over-engorgement of the womb, caused by the afflux of blood to the cervical sore, brings about the pathological turgescence of the vascular appendages of the womb. Hence the persistence of the ovaritis, or of the peri-uterine inflammations. Cure now the chafed and angry cervical sore—the *fons et origo mali*—and you lessen the monthly afflux of blood, and, consequently, the monthly exacerbations of the upper pelvic lesions. Acting upon this idea, I have, on several occasions and under such circumstances, performed the operation, and thus far I have every reason to congratulate myself for taking this responsible step.

Another occasional indication for the operation is the presence of dense cicatricial tissue in the angles of the fissure, always provided that various pelvic neuralgiæ and distant nerve-perturbations can be satisfactorily traced to the cervical injury. Sometimes this can be proved by the tenderness of the cicatrix, coitus, or the pressure of the sound on some point eliciting radiating pains.

Often the relation must be inferred either from the monthly exacerbations, or from the exclusion of other causes. The diagnosis is not always easy, and I am sure that I have here made mistakes—that is, I have removed wedges of cicatricial tissue without restoring by that means my patient to health. From my observations I am disposed, indeed, to believe that the baneful influence on the system of hard and gristly cicatricial tissue left after some cervical tears has been overrated. I am willing to concede that sterility is sometimes owing to it, as it clearly was in one of my patients who became pregnant immediately after the operation. I am also ready to grant that reflex pains and visceral disorders may come from it; but I am inclined to look upon these results as exceptional, and that a tear of the cervix is too often made the scape-goat of headaches and nape-aches, of spine-aches and back-aches, and of various other nervous explosions, which are due to nervous exhaustion or to nutritive changes in nerve-centres, rather than to traumatic injury of their extremities. In other words, the constitutional phenomena are dependent usually on fine central lesions, and not on the reflex influence of coarse peripheral injuries. My experience would lead me to say further that, while a woman is suckling her infant, and menstruation is thus kept away, she may not appreciate the evil effects of even a bad laceration; but as soon as she gives up suckling, and the monthly congestions begin, very exacting local and constitutional symptoms soon set in.

Of the beneficial results of the operation of trachelorrhaphy, I must candidly admit that I am not now so sanguine as at first. The broad rule may be laid down that, when marked ectropion exists, associated with enlarged Nabothian

glands, with leucorrhœa and menorrhagia, the issue of the operation will be a happy one. When, however, I have operated on a tear without ectropion, or merely on account of cicatricial tissue in the angles of the fissure, I have met with some bitter disappointment.

My mode of operating is, first to coaptate the parts by two tenacula, and to determine with the sound the proper site for the new os externum. At the very centre of this site, the two lips of the fissure are transfixed by a powerful needle armed with a stout silver wire about two feet long. The ends of this wire being twisted together, form a long loop, which puts the womb under perfect control. By it, the womb is gently drawn down and put within operative reach. By hooking up with a tanaculum that portion of the wire running across the fissure, viz., its middle, the loop is doubled at the expense of its length, and by separating the two loops, the lips of the fissure are drawn apart. The denudation I now prefer to make with a knife, trying always to remove all the cicatricial tissue, and in one piece, if possible. After the denudation, the wire is again converted into a single loop, by releasing its middle portion and drawing it back. This brings the lips together with mathematical precision, and shows whether any further trimming is needed. I always shot my sutures, and very generally shot also the guiding or piloting suture. To facilitate the drawing down of the cervix and the removal of the stitches, I leave uncut the ends of this wire and those of the highest suture on either side. I try, of course, to operate at a time when the catamenia will not be reproduced, or be precipitated. But, in spite of this caution, I have often had the menstrual flow to occur a very few days after the operation; yet, in not a single instance has

such a misadventure interfered with the prompt and perfect union of the parts. On several occasions I have, at the same operation, curetted the womb for those vegetations which are so likely to be found in the endometrium in cases of old cervical tears; but while this is a great saving of pain and of time to the woman, and has thus far not been followed by bad results, I deem it too unsafe a practice to be generally resorted to.

[The statement that "the more children a woman has given birth to the greater her liability to cancer" needs confirmation. We hope and believe that it is incorrect. The simple mention of such a thing will be agreeable to the host of American women who shrink from maternal duties. Dr. Goodell is a believer in the cicatricial "plug" which Emmet finds in the angle of the fissure. We have long doubted the existence of such a mass of scar tissue, and since reading the valuable paper of Dr. Wylie, in the *American Journal of Obstetrics*, for January, 1882, our doubts have grown to disbelief. The results obtained by Dr. Goodell favor our present views. The Doctor's method of operation is different from, but no improvement upon Emmet's.]-A. J. C. S.

The Hygienic and Dietetic Regimen of Uterine Therapeutics.

BY HORATIO R. BIGELOW, M.D.,
Washington, D. C.

Of equal importance with the active local treatment of uterine complaints are, the little details of every-day life, which are often lost sight of altogether, or else deemed of little or no importance. They are so simple as to be forgotten. It is safe to say that no active interference in inflammations and dislocations, will, unaided by strict attention to hygienic detail, accomplish a cure. It is by enjo-

ing a faithful observance of these things that the physician will achieve the greatest reputation. Modern therapy has achieved no greater distinction than a recognition of a well-ordained home life.

It is far-sighted in differentiating in those cases which need active interference as opposed to others which merely call for rest, diet, and exercise.

The daily employment of certain movements is one of the most useful aids in uterine therapy. Most women suffering with mal-placed uteri are unable to take proper exercise. Standing fatigues them, walking is painful, and they groan incessantly with backache. The life of indolence induces constipation, dyspepsia, and nervousness. The muscles become flaccid and weak, they lose strength, even though they may gain in flesh.

Clothed in a loose wrapper, or simply covered with a blanket, the woman should lie flat upon her back upon the floor, with her legs close together, and the arms extended by the side. The left arm should then be *slowly* raised to a position perpendicular to the body, and then carried as far backward as possible. The arm is then to be as slowly returned to its original position. This should be repeated three times, and then resumed with the right arm. After a slight rest, the left arm is to be raised to the perpendicular, and then carried across the body to the right side. This also should be repeated three times, and then taken up by the right arm. Each leg is then to take up the movements just finished by the arms, except that, after gaining the perpendicular, they are not to be carried back toward the trunk. Another short rest follows, then both legs are to be raised simultaneously with the feet touching, the patient resting squarely on her back. This is to be practised three times. This movement

is a difficult one, even for a person in robust health, but with each effort it will become easier. Then, turning over, resting upon her elbows and toes, the woman is to raise herself as much as possible.

Another exercise is for her to sit side-wise upon a chair having no arm-rests, and while the feet rest upon the floor, the body is to be bent backward as far as possible and then returned to an upright position. Each movement is to be practised three times. Then, standing erect, with the right foot resting upon a chair, and the hands upon the hips, she is to rotate her body from left to right, using her hips as a pivotal point. She then changes her feet, placing the left upon the chair, and rotates the trunk from right to left. She may then stand erect upon both feet, and placing both hands upon the head, with the arms bent, she may rotate the head in the same way that she has done the body. This movement of the head and trunk is of great importance in the treatment of dyspepsia resultant upon uterine disorder. It is marvellous how quickly some attacks are dispelled during the exercise. Should the uneasiness persist, brisk rubbing over the lesser curvature of the stomach will dissipate it.

If obstinate constipation prevail, I know of nothing so valuable as massage. Having slightly moistened the tips of the fingers of the right hand, they should be pressed gently over the cecal region, then they should be carried up over the ascending colon to the right hypochondrium. The movement should be continued steadily over the transverse colon for some little time, and the pressure should be considerably increased as the fingers are carried down the descending colon. With a slight rest, the movement may be resumed, and so continued for ten or even fifteen minutes. If the case

be very intractable, and the patient cannot effect the desired result herself, a nurse may easily be trained to do it for her.

A tepid bath of sea salt upon going to bed is of great service in the management of these cases. The sponging of the body to be followed by brisk rubbing with a Turkish towel. The clothing should be loose around the hips, and its weight supported by the shoulders. The heels of the shoes should be square and low. This latter should be insisted upon by the physician and should never be lost sight of.

In certain conditions of retroversion with descensus the patient should be instructed to assume the knee-chest position after exercising.

Of the management of the menstrual period perhaps the best plan is to allow the woman to do that which she feels most like doing. She should refrain from indulging in any amusement after dinner that may have a tendency to excite her or to keep her awake.

Treatment for Certain Kinds of Incontinence of Urine in Women.

BY J. MILNE CHAPMAN, M.B., M.R.C.S.

Mrs. C., aged forty-eight years, had frequent and painful micturition that had lasted three years and a half. When first ill a doctor told her she had inflammation of the bladder and some urethral affection (caruncle?), for both of which he treated her. September 30, 1880, could only retain water half an hour. The pudenda were reddened, also the whole vagina. Urethra somewhat gaping at its outlet. There was considerable pain on rubbing the two walls of the bladder over one another, or on introducing the sound into the viscus. Urine turbid, acid, and contained pus-cells, bladder-epithelium, and some

oxalates. Urethra was dilated by the finger, increasing the bladder's retaining limit to an hour and a half. Nux vomica and uva ursi were given and the vaginitis treated by sedative applications. Effects of the dilation disappeared in about three weeks. It was then repeated, but soon she relapsed into her former condition, minus, however, the pain and pus in the urine. Urethra examined by endoscope and a slight redness noticed. Iodoform bougies were used. Condition of bladder-wall, as seen by the endoscope, was normal, and now (November 8th) every hour, night and day, she has to empty her bladder. Total quantity of urine fifty ounces, which gave little more than two ounces at each micturition. Sound passed into the bladder three inches from external meatus, and could only be pushed half an inch farther, and thus pain was caused.

It occurred to me that gradual forcible dilatation of the bladder might relieve the patient. The bladder was distended with warm two-per-cent. carbolic solution, and the quantity used measured four ounces. Any attempt to inject more caused the most intense pain, and the resistance was great as could be felt in compressing the ball of the syringe. From this date the bladder was filled to distention daily, injection being stopped when pain became great and resistance reached a high point. The apparatus used was Higginson's syringe attached to an ordinary catheter, care being taken to prevent the access of air to the bladder. Each day there was a gradual increase in the amount injected of from a drachm to an ounce. On two or three occasions the fluid as it returned was tinged with blood, but no harm ensued.

December 20th she was discharged. Instead of micturating every hour she

had only to get up once or twice during the night. Sixteen ounces could now be injected and less pain caused than when four ounces was the limit. Two months later she was as well as when she left the hospital.—*Louisville Med. News*.

Boracic Acid in Vesical Catarrh.

Prof. ROSENTHAL, of Vienna (*Weiner Med. Blatter*), has derived decided benefit from boracic acid in various forms of catarrh of the bladder.

R. Boracic acid, pure, 1 part; warm water, 20 parts; hot glycerine, 5 parts.

M. This mixture will keep well for months, and may be given in teaspoonful doses once or oftener daily, in a glass of water.—*New England Medical Monthly*.

Pruritus Vulvæ.

Dr. E. BESNIER (*Louisville Medical News*) finds the following ointment most efficacious: R. Ung. diachyli, Ol. oliv., aa 3 iv.; 16.00 gm.

Pruritus Vulvæ Relieved by Iodide of Potassium.

At a meeting of the St. Louis Medico-Chirurgical Society, Dr. BRYSON related the following case: Having under treatment a patient suffering from fistula in ano and urethral stricture, he learned that the man had syphilis, and gave him constitutional treatment with potassium iodide while he was dilating the stricture. Not long after he was called to treat the wife of this patient for most intolerable pruritus vulvæ. The general condition of the woman seemed to be very good; but she had been married seven years without bearing any children, and had once aborted in the third or fourth month of pregnancy. These facts, in connection with his knowledge of the husband's history, led the doctor

to suspect a syphilitic taint in this woman; and he prescribed potassium iodide in doses of three grains three times a day, which was gradually increased to ten grains three times a day. No local treatment was used, and in three days the distressing pruritus entirely disappeared. The iodide was continued for some weeks longer, with marked improvement of the spirits and health of the patient.

There was no eruption or other lesion characteristic of syphilis apparent about the vulva, and Dr. Bryson considers that the trouble was due to an obscure syphilitic nerve affection.—*St. Louis Courier Medicine*.

Berberis Aquifolium in Leucorrhœa.

Dr. A. J. ROE (*Therapeutic Gazette*):

When there is simply a leucorrhœal discharge, the patient being otherwise in good health, I usually order one ounce of the fluid extract of berberis aquifolium to be added to three ounces of the syrup of tolu, and let the patient take a teaspoonful three times a day before meals. No local application of any kind need be used. The following combination has given me excellent results in all cases of leucorrhœa, amenorrhœa, dysmenorrhœa, and as a general uterine tonic and "female-regulator":

R. Ext. berberis aquifolii fluidi, $\frac{3}{4}$ j.
—32.00 fl. gm.; ext. viburni prunifolii fluidi, $\frac{3}{4}$ ss.—16.00 fl. gm.; tinct. pulsatillæ, $\frac{3}{4}$ j.—4.00 fl. gm.; syr. tolu, q. s. ad, $\frac{3}{4}$ iv.—128.00 fl. gm.

M. S.—One teaspoonful three times a day, before meals, in water.

In Chronic Leucorrhœa, Acute and Follicular Vaginitis.

R. Plumbi acetat., grs. xx.; ext. opii, grs. xxiv., olei theobromæ, $\frac{3}{4}$ j.; glycerinæ, $\frac{3}{4}$ ij.

Mix.—Divide into eight pessaries, and

order one to be used every night.—*Med. Gazette*.

Leucorrhœa.

R. Zinci oxidi vel bismuth carb., grs. lxxx.; ext. belladonnæ, grs. xl.; olei theobromæ, $\frac{3}{4}$ j.; olei olivæ, $\frac{3}{4}$ ij.

Mix.—Divide into eight pessaries, and order one to be used every night.—*Ibid*.

Treatment of Chronic Ovaritis.

Dr. P. F. MUNDÉ (*Med. Gazette*):

The treatment is almost entirely local. A blister should be applied once or twice a month over the ovarian region, to be alternated in the intervals with tincture of iodine; then pack the vagina full of cotton soaked in glycerine; use injections of hot water with the addition of a little glycerine twice a day, a gallon each time, the patient being in a recumbent position, with the hips elevated, in order that the water may stay in as long as possible.

This should be continued for weeks and months. Internal treatment consists chiefly of the administration of tonics. There are two or three ovarian sedatives; the bromides may be given either in combination with sodium or potassium. You may reduce the size of the ovary by giving the patient morphine or bichloride of mercury 1-24 of gr. 2 or 3 times daily, combined with the muriate of ammonia in 5-gr. doses. The chloride of gold and sodium in doses of 1-20 to 1-4 gr., 3 times a day in a pill, may also be given with advantage.—*Ibid*.

[It is not easy to understand how the size of the ovary can be reduced by morphia. It would also be trying treatment for the patient to pack the vagina with cotton and use hot-water injections twice a day for months.]—A. J. C. S.

In Amenorrhœa with Torpid Circulation.

R. Potass. iodidi, gr. xviii.-xxx.; ferri et ammon. citrat., gr. xl.; tinct. nucis vomicæ, 3 j.; infus. quassia ad., 3 viij.

M. Sig.—One-sixth part three times a day.—*Ibid.*

Where the Menstrual Flow is Scanty and the Liver Sluggish.

R. Podophylli resinæ, grs. vi.; ext. hyoscyami, grs. xxiv.; ext. nucis vomicæ, grs. iv.; pil. aloes et myrrhæ, grs. xxx.

M.—Divide into twelve pills, one to be taken at bedtime three or four nights in succession.—*Ibid.*

Cliterodectomy.

Dr. GEORGE J. ENGELMAN contributes a very valuable and interesting paper on this subject to the *American Practitioner* for January. He thinks the operation has fallen into undeserved disrepute and advocates its performance in certain cases. His justification for the operation is based upon a recognition of the importance of reflex action in female suffering. He gives a complete record of one case (the only one he has ever seen), in which a lady fifty-two years of age was placed under his care for the following condition: She had always suffered much from headache, and was very nervous, easily flushed by worry and excitement. She has had eleven children; menstruation had always been regular, but profuse, until about six years ago, when, after eighteen months of irregularity, it ceased altogether. She complains of nervous attacks, originating sensibly in the region of the clitoris, and culminating in melancholia. All the symptoms of the attack evidence a profoundly nervous condition, and great derangement of the general health. After lasting a variable period, these

symptoms would suddenly disappear, and she would have two or three weeks of comparative comfort, followed by a fresh attack, until life became a burden. Examination revealed an irritated vulva, carunculæ myrtiformes, and very much enlarged nymphæ and clitoris. He removed the carunculæ, and subsequently amputated the clitoris and nymphæ. The patient made a good recovery, and while under his care was entirely free from bad symptoms. Some months afterward, however, when she had returned home, the old attacks came back with full force; but Dr. Englemann attributes this relapse to a return to her old habit of masturbation, which, of course, the presence of the nurse had prevented. The question therefore arises, whether her nervous attacks were due to the enlarged clitoris or to masturbation. This opens up a wide field for investigation.—*Med. & Surg. Reporter.*

Tetanus After Ovariectomy.

Dr. S. M. BENNETT (*Lancet*) has recently had under observation a case in which tetanus came on sixteen days after an ovariectomy. The disease was treated by atropine, quinine, physostigma, chloroform, morphine and nicotine, but the patient died eighteen days after the operation. Cases of this kind are exceedingly exceptional.—*Chic. Med. Rec.*

As a Local Anæsthetic in Cancerous and Other Painful Uterine Diseases.

R. Idoformi, grs. lxxx.; olei theobromæ, 3 j.; glycerinæ, 3 ij. Mix. Divide into eight pessaries.—*Med. Gazette.*

Hydro- and Pyo-Salpinx: their Causation, and the Normal Position of the Ovary.

At a recent meeting of the London Pathological Society, Mr. Lawson Tait exhibited twelve specimens, with the ob-

ject of directing attention to the pathological anatomy of diseased Fallopian tubes. The patients had, with one exception, been married and pregnant, but had been long under treatment for menstrual irregularities and distress. As bearing upon the etiology of such affections, it was observed that the cases (nine in number) had each given a history of some previous pelvic inflammation, of pain on exertion, during sexual intercourse and menstruation, and of tender, fluctuating, localized swellings on the sides of the uterus. The treatment recommended was excision of these uterine appendages. Tapping was held to be difficult, and, if practised, useless. All of the operations proved successful, and the patients (twenty-two in number) were completely cured. Menstruation was stopped, but the marital function was restored. Ovaritis is named as the primary disease, the inflammation extending progressively along the tube to its uterine extremity. In commenting on these cases, Mr. A. Doran alluded to the falsity of our prevailing opinions as to the relation in position between the ovary and the fimbriæ of the Fallopian tube. Instead of overhanging the ovary, the fimbriæ lie beneath or to the outside of it, and therefore the "*morsus diavole*" is a delusion. The ripe ova have simply to drop into the tube, and they may be fortunate enough to fall at once among the spermatozoa. Pathological anatomy corroborates this view, for, when adhesions takes place between the ovary and the fimbriæ, the latter underlie or are to the outside of the former.—*Lancet—Medical Record.*

Spontaneous Cure of Vaginal Hernia.

An extraordinary case of spontaneous cure of vaginal hernia, followed by perforation, has occurred in the service of M. Auger, of the St. Antoine Hospital.

A woman, aged twenty-five years, mother of two children, became for the third time *enccinte*, and being displeased at this new pregnancy, consulted a midwife as to the best means of procuring abortion. Injection of tepid solution of coarse salt was advised and practiced. The syringe employed had a long canula, and its introduction into the vagina caused considerable pain. Three injections were used, an interval of a week being allowed between each, and soon hemorrhage very abundant was excited. On the day of her entry into the hospital the patient, on sneezing, felt a tumor in the vagina, and soon it appeared at the orifice. Frightened, she came to the hospital, when, on examination, a tumor of a dark violet color, and resembling a loop of intestine, was observed between the labia. It was soft and seemed to contain gas. On exploring with the finger in the vagina the hernia was partially reduced, but it was impossible to find the point through which the intestine passed, neither could the os uteri be reached. However, no loss of substance could be detected in the recto-vaginal wall. There was no nausea or vomiting, the pulse was not accelerated, nor was the temperature lowered; the abdomen was not tympanitic. Rest and constant poulticing were ordered. The following day the tumor was observed to be of a darker hue, which, toward evening, became still blacker and more salient. It also smelt gangrenous. The general health remained always undisturbed. On the afternoon of the third day the bowel burst, giving exit to hardened fecal matter, mixed with a blackish and fetid liquid, and a great quantity of gas. For two days fecal matter continued to pass through the artificial anus in abundance, but on the fourth day it had completely ceased, the bowels evacuating themselves through

the rectum regularly. On passing the finger into the vagina no trace of the recent perforation could be found. Examination by the speculum gave no better results. On the twentieth day of her residence in the hospital the patient returned home in her usual health.—*Med. Press and Circular — St. Louis Med. News.*

Prolapse of the Uterus.

M. GUENIOT gave an account of five personal observations of prolapse of the uterus treated by uniting the posterior and anterior walls of the vagina (*Cloisonnement*) by the operation practiced by M. le Fort. M. Després considered that every operation made to restore the uterus to its position was useless, for the real cause of prolapse was the insufficiency of the perineum. The perineum is composed not only of skin but muscles, and it is to the weakness or insufficiency of these last that prolapsus is to be attributed. It suffices to make the patient cough to recognize this fact. M. le Fort could not accept this theory of M. Deprés; on the contrary he considered that the perineum had nothing to do with prolapse of the uterus. M. Trelat was of the same opinion, and believed that the operation of M. Deprés (suture of the inferior third of the vulva) as worse than useless.—*Med. Press and Circular.*

DISEASES OF CHILDREN.

Examination of Children.

W. T. PLANT, M. D. (*Obstet. Gazette*):

First, win the confidence and goodwill of the little one. Get the history of the sickness from the mother, and while receiving that, you may notice the child without seeming to. Notice the

physiognomy. The features of a child under three or four months have little expression, but beyond this period they may be taken as an honest declaration of its feelings. In acute diseases attended with fever, the cheeks, and perhaps other parts of the face, are flushed from congestion. If the redness is circumscribed and transient, appearing on one or both cheeks, the forehead or the ears soon fading into paleness, to reappear after an uncertain time, we have in this a reliable sign of serious brain trouble. Drooping of the upper lids, squinting, rolling of the eye-balls, fluctuating or unequal pupils, or a steady gaze on vacancy, associated with fever, are symptoms that point in the same direction. A small, pinched face, overtopped by an enormously enlarged head, characterizes hydrocephalus. Rapid out and in movement of the alæ nasi, with flushed and anxious countenance, attend severe inflammations of the respiratory organs. I know of no disease that will change the physiognomy of a little child so quickly as a diarrhœa, with copious watery dejections. I suppose that full three-fourths of the weight of a child's body is water; and its rapid abstraction by an intestinal flux, may, in a few hours, work such changes in a plump and ruddy face that it is scarcely recognizable.

Notice also the voice. Diseases that produce great debility render the voice weak and plaintive. In pneumonitis and peritonitis it is restrained, because its exercise causes pain. Fits of loud crying are evidence of the absence of these diseases. In croup, and other affections of the larynx, the voice is apt to be hoarse and brassy. Hoarseness is also an early sign of congenital syphilis. Some cases of cerebral inflammation are attended by an occasional solitary, piercing cry—a cry so

peculiarly expressive of agony that it is not easily forgotten. Sighing is a symptom frequently seen in like cases.

Cough is very frequent in children. After taking cold, the cough is dry at first from diminution, but becomes moist at length, from an increase of bronchial secretion. The cough of pneumonitis and pleuritis is apt to be restrained. That of whooping-cough is always paroxysmal after the first stage, though the whoop is not always present. The cough that accompanies some forms of heart disease is dry, stuffy and frequent. A laryngeal cough is peculiarly loud and resonant—clarion like. Stomach and intestinal irritations, as from worms or undigested food, also cerebral and spinal irritations, often give rise to a persistent, dry cough, from reflex nervous influence. Lastly, continued fevers in children are often attended throughout their course by a hacking cough, difficult to subdue, and more annoying than dangerous.

Notice, again, the position and movements of the patient. If very weak, it lies upon its back without much movement of its limbs. If the head is retracted and cannot be brought forward without pain, if the body is rigid, and there are muscular spasms and twitchings, this condition points strongly towards cerebo-spinal irritation or inflammation. If any of the abdominal viscera are inflamed, the child prefers to lie on its back with the limbs drawn up. In colic the prone position is chosen because pressure gives relief. Children often carry the hand to the seat of pain—to the forehead in headache, to the ear in earache, to the gums when teeth are coming. Rubbing the nose and upper lip is popularly regarded as a sign of worms. It may be due to these, or to any other irritant in the alimentary track, to a cold, or a dose of Dover's

powders or other opiate. In spinal and hip diseases, children instinctively assume positions so characteristic that they are of great diagnostic value. In all conditions of the respiratory organs, in which the need of air is urgently felt, there is apt to be extreme restlessness.

All the exanthemata may be known by inspection of body. Congenital syphilis, by coppery discolorations of the surface and eruptions around the anus. In infants, the first stage of intermittent fever is seldom attended with shaking, as in older people, but by lividity and paleness of the skin and a characteristic goose-flesh appearance. Jaundice, a frequent ailment in the newly born, imparts a yellowish tinge to the surface.

In grown people we make much of the pulse; not so with children. It is usually absent at the wrist for a week or ten days after birth, and throughout infancy it is feeble and very rapid. A preternaturally slow pulse is of importance, being one of the ordinary accompaniments of serious brain disease.

In children the temperature is liable to sudden increase from slight and transient causes. A fit of indigestion, or even an outburst of anger with hard crying, will cause the temperature to mount to 103° or 104° .

In the very young infant, the breathing is frequently intermittent and irregular. There may even be pauses of such considerable length between the inspirations that the mother fears the cessation of the function. Like the pulse, the breathing is liable to great disturbance from slightest cause. Exercise, emotional excitement, or a transient fever, may increase it as much as more serious ailments. In capillary bronchitis and pneumonitis, the respiration is quickened. In acute pleurisy, and in peritonitis, it is short and difficult

from the increase of pain to which the movement gives rise. In all acute febrile affections in the young child, respiration is apt to be rapid and panting. In acute encephalic inflammations the respiration as well as the pulse may be abnormally slow and intermittent. In obstructive disease of the larynx and trachea, as croup, inspiration is prolonged, and, if the obstruction is considerable, is accompanied by a peculiar wheezing sound.

Auscultation and percussion will fail of that diagnostic precision which is so easy of attainment in the adult. We may always know by auscultation whether the lungs are freely and equally pervious to air, and by percussion whether there is any considerable dullness in any part of the chest. If a stethoscope can be used without frightening the child, it is preferable to immediate auscultation, because with it the sounds are collected from a restricted area, while adventitious noises from the nares, the larynx and the stomach are excluded. It is my habit to begin this examination at the back to avoid frightening the child.

Inspecting the tongue and inner side of the mouth had best be made last, since it is pretty likely to provoke crying and a lusty resistance, which, occurring earlier, would interfere with and retard your work. To examine these organs the patient should be brought in front of a good light. While the nurse holds it and controls its hands, the mouth may be opened by pressing the chin downward. The tongue being in view, notice the condition of its upper surface. If coated, observe the color and depth of the fur, and whether there is any undue prominence of the lingual papillæ. In infants, examine the inner side of the mouth for aphthous sores; also, if at an age when teeth may be coming, pass the index finger backwards

over the gums and ascertain their state as to heat and turgescence. If there is ground for the least suspicion of throat trouble, do not neglect to make an examination. This is easily accomplished by steadying the head and passing the handle of a teaspoon over the dorsum of the tongue nearly as far backwards as the circumvallate papillæ, and making downward pressure.

Notes on the Pathology of Rickets.

By DR. ADOLPH BAGINSKY, Berlin
(*Amer. Journ. of Obstet.*):

1. The clinical experience, that congenital rickets is met with, that the majority of children born with congenital syphilis become rickety even under the best nursing, that rickets arise as a sequela of grave febrile diseases, and of grave chronic gastro-intestinal disorder, that it arises in consequence of bad nourishment and want of fresh air, the further experience that rickets is associated with considerable troubles in the nervous system (laryngismus stridulus, hydrocephalus, hypertrophy of the brain), all combine to exclude, from a clinical point of view, the possibility of explaining the disease, by a simple deficiency of the inorganic constituents of the bone.

2. The opinion that rickets consists only in a deficiency of the lime is also excluded by the fact, that the proportions between the inorganic and organic (minus fat) constituents of the bone are so considerably altered—160:100 instead of the normal 563:100—that supposing the lime is eliminated from the food of the child for a whole year, the proportion would by a proximate estimate be found to be still 513:100.

3. In a certain opposition to these clinical experiences are the experimental studies of some authors (principally

Roloff in Berlin), who have proved that rickets may be produced in animals by withdrawing lime from the food.

I have repeated these experiments, and found :

a. Simple elimination of lime from the food produces, in fact, considerable changes in the bone.

b. The change appears macroscopically and microscopically about the same as a slight ricketty change.

c. The degree of change produced is, as it is shown by anatomical, and principally by chemical examination, only a mild one.

4. If besides the elimination of lime from the food lactic acid is added to the latter, the alterations are considerably increased. This is shown by :

a. By the macroscopical and microscopical examination of the bone.

Ear Affections in Childhood from Dentition or a Carious Tooth.

"A considerable portion of the blood supply of the membrane of the drum is derived from an artery that leaves the internal carotid in the carotid canal and proceeds by a very short course directly to its destination. Being thus closely connected with a large arterial trunk, this small tympanal branch of the internal carotid possesses very favorable circumstances for a speedy augmentation of its blood supply. The nervi vasorum constituting the carotid plexus at this part of its course come largely from the otic ganglia. On the other hand the inferior dental nerve supplying the decayed tooth or the gums, as the case may be, also communicates with this ganglia. We thus arrive at a direct channel of nerve communication between the source of irritation of the tooth and the vascular supply of the drum-head.—*Cin. Med. News.*

Atrophy of Finger-Nails.

Dr. SEESSEL reports the occurrence of unguis atrophy occurring in a child, and recently observed by him. After recovery from an attack of croupous pneumonia, the patient developed several abscesses. One of them was situated in the axilla, and, by pressing upon the nerves, caused an atrophy of the finger-nails. Regeneration of the atrophied nails subsequently took place. This was a purely trophic, in contradistinction to the so-called vaso-motor disturbance.—*Ibid.*

Hæmatemesis in an Infant.

Dr. E. A. TRAVIS (*Louisville Med. News*): On the night of January 6th, I was called to see an infant, two days old, which had been subject to attacks of hemorrhage since its birth. The blood was vomited every two or three hours, the quantity varying from one to two ounces at each repetition of the bleeding. On my arrival the countenance was pale and anxious, the pulse quick and very feeble, the child refusing to take the breast. All outward signs seemed to point to a fatal ending.

Never having seen or read of such a case, I was naturally at a loss for a remedy, but finally gave one drop of fluid ext. ergot and a grain of chloral, to be administered after each attack. Improvement began at once, the hemorrhage ceased entirely on the third day, and the child took the breast naturally. It will be seen that in this case large doses were given to a very young child with impunity.

"Inward Fits" in Children.

Dr. CHARLES BELL writes on this subject in the *Edinburgh Medical Journal*:

This is a common disease in infants within a few months after their birth.

The child lies as if asleep, but the eyelids are partially open and have a twinkling motion, the eyes are turned up so as to show the white, the muscles of the face and lips have a tremulous movement, producing the effect as if the child were smiling—a circumstance which has given rise to the beautiful idea that angels are whispering to it, which has been finely illustrated by Moore in his *Irish Melodies*, under the name of "The Angel's Whisper." As the disease increases the breathing is occasionally interrupted, the features become pinched, and a livid circle forms around the mouth and eyes. There is restlessness and starting during sleep, and the child is disturbed by the slightest noise, and sighs and brings up wind, after which it relapses into a drowsy state. In simple and mild cases the attacks generally disappear as the child's strength improves; but if it is improperly treated, the drowsy state increases, and a sort of thrush appears, accompanied by feverishness, sour vomiting, watery stools, gripes, which may terminate in regular convulsions.

Dr. Armstrong has divided this disease into four stages, viz.: 1st, inward fits; 2d, fever and thrush; 3d, sour vomiting; 4th, convulsions. Underwood did not consider it worthy of being called a disease, and that he knew no complaint which ought to be called "*inward fits*;" the symptoms described above were worthy of attention only from the risk that they might pass insidiously into regular convulsions—an amply sufficient reason for their being carefully attended to and means taken for their being removed.

The incipient stage which occasioned the name may occur at very early periods, and the earlier it does so, there is the greater danger to be apprehended. Nurses often use the terms on insuffi-

cient grounds, and in consequence the mother is apt to become needlessly alarmed, and to have recourse to very improper medicines, such as Dalby's carminative, Godfrey's drops, Soot drops, etc., which are liable to produce serious results.

It has been connected with spasm of glottis, with acute asthma, the peculiar species of convulsions, cerebral croup, laryngismus stridulus, thymus, asthma, or spasmodic croup by different authors.

Treatment.—It is clear that the symptoms which have just been described are the result of something irritating the bowels, and that a dose of magnesia will in general be sufficient to remove it. Should this not be the case, it may be necessary to attend to the state of health of the nurse, and to give the child the benefit of change of air.

OBSTETRICS.

Colpeurynter in Placenta Prævia.

ISAAC SCOTT, M. D. (*Med. and Surg. Reporter*) :

Mrs. P., from the sixth to the ninth month of her gestation, had a number of attacks of hemorrhage. I was hastily summoned to see her. On examination found the os uteri but slightly dilated, and the placenta interposed between my finger and the head of the child. I immediately introduced Braun's Colpeurynter into the vagina and distended it with warm water till it completely filled the passage. This at once checked the hemorrhage. I let the colpuyrenter remain for four hours, during which time not a drop of blood passed. I then gave her a full dose of fluid extract of ergot, removed the colpuyrenter, and finding the os uteri dilated, I immedi-

ately introduced my hand, turned and delivered the child with all possible haste, the afterbirth coming away in advance of the child; by using brisk friction and compression over the region of the womb, contraction took place rapidly, and the woman had a good but slow getting up. By using artificial respiration the child was soon resuscitated. I have found the colpuyreuter vastly superior to the old fashioned tampon, or Barnes' dilator, not only in placenta prævia, but also in abortion cases and in bringing on premature labor in cases of contracted pelvis.

Placenta Prævia Complicated by a Large Myoma.

Dr. HICKINBOTHAM (*Amer. Jour. of Obstetrics*): The patient was a delicate primipara, of small stature, at full term. She had previously aborted. She had been in labor six hours and had lost much blood. The os was dilatable, large enough to admit two fingers. The placenta presented completely; no edge could be felt, and through its centre, which seemed to be the inner part, a rounded mass was felt, and supposed to be the fetal head. The author decided to break through the centre of the placenta with the view of turning. Having torn through it, he discovered that the round mass was a large tumor, upon which the placenta was attached. The delivery of the placenta was therefore completed, after which the hemorrhage greatly abated, version was performed, the aftercoming head perforated, and extraction effected with the aid of the crotchet. A terrible attack of septicæmia followed, and for a fortnight I almost despaired of the patient's life. The tumor sloughed, and became protruded through the os. On the

tenth day a softened and fetid portion was extracted, and the remainder painted with pure carbolic acid. In three months the uterus was freely movable and its cavity of normal length, but the patient had not again menstruated after eleven months. If the placenta had not been prævia, the author would have preferred Cæsarean section.

Milk Diet in Renal Dropsy.

M. CHAUTREUIL (*Gaz. des Hôpitaux*) records a number of cases of general dropsy with albuminuria occurring in the later months of pregnancy, which were relieved and uræmic eclampsia apparently prevented by milk diet. In cases in which there was swelling of the feet and legs, with more or less general anasarca, and abundant albumen in the urine, milk diet preserved in for a short time had the effect of removing the anasarca and diminishing the quantity of albumen in the urine. In one case the quantity of albumen was greatly lessened and the patient did well throughout, while in her previous confinement she had a severe attack of puerperal eclampsia.—*Can. Lancet*.

Morphine in Puerperal Eclampsia.

Dr. C. P. CLARK (*Amer. Jour. of Obstetrics*) says he has never seen opium, properly used, fail to ward off eclampsia when it seemed to be threatened; that he has many times seen it obviously and at once put a stop to the paroxysms after they had been commenced; and that he has never known a patient to die of this disease when that medicine had been administered in season, in sufficient quantities, and in the proper manner.

When premonitory symptoms of eclampsia appear, continuous or paroxysmal pain in the head, alterations and

figments of the senses, especially of sight, mental dullness, ataxy, a countenance expressive of suffering and apprehension, an irresolute and incapable manner, and complaint of indefinable distress, he orders two or three grains of opium per deim, with full confidence that convulsions will be warded off. He does not ignore eliminants, but does not trust to them alone or chiefly.

When the convulsions have appeared, the patient "should have forthwith injected into her arm a grain and a half of morphine *by weight*." "Should the paroxysm return any time after two hours, this dose should be repeated. And if she be in labor, she should have another dose after eight hours any way."

He asserts that a comatose or half-comatose condition is no contraindication to such use of morphine; and he urges that this course be pursued unhesitatingly unless the patient be obviously moribund; and has the greatest confidence that morphine so used will succeed in all cases where the brain has not already sustained irreparable injury by a long succession of paroxysms, or by a few of great violence.—*Can. Med. Record*.

Puerperal Eclampsia.

The weight of opinion seems to favor chloral in large doses in the rectum. Guyot (France) reports remarkable success, thirteen or fourteen cases being saved. He injected into the rectum from one to four drachms in twenty-four hours. Dr. Goodell believes it the best single remedy. He directs a drachm by rectum, or twenty grains by mouth, repeated as often as may be necessary, and asserts that he has never lost a case. Other writers are equally laudatory of chloral, while none discard chloroform. With regard to the induction of prema-

ture labor in eclampsia, there seems to be a growing sentiment in its favor, and successful cases are recorded.

Blood-letting is apparently growing in favor again. Many writers advocate it, or at least speak of it as a too much neglected remedy.—*South. Practitioner*.

External Use of Jaborandi in Mammary Inflammation.

Dr. HARRY B. STEHMAN: Mrs. K., multipara, on the sixth day after confinement, had much pain in the left breast, which had become hard and swollen, with considerable fever, pain in head and back. In examining the breast I discovered a large cicatrix, and on inquiry learned that in her second confinement she had suffered in a similar manner; that the inflammation went on to suppuration, and finally the breast was lanced. I prescribed a diaphoretic mixture, and locally used a poultice composed of two parts flaxseed meal and one part crushed jaborandi leaves. The leaves were infused in a quantity of hot water necessary to make the poultice of proper consistence, in order that the active properties of the jaborandi might be more thoroughly mixed with the meal. These poultices were continued for forty-eight hours; at the end of the first twenty-four the breast was flaccid, the swelling reduced, and the pain had disappeared.

There was no milk drawn from the breast in the interim, and the most gratifying feature was the fact that the engorged breast was entirely relieved. At the end of the second day the treatment was discontinued, the milk flowed freely, and the mother nursed the child from this breast as well as the other. I have used this treatment in a number of similar cases since then, and have never seen it fail, if adopted before suppuration had set in.

I have used these poultices in the inflammatory stages of buboes, and succeeded in preventing suppuration. In mumps this treatment proved equally gratifying.—*Coll. & Clin. Record.*

Parsley as an Antigalactic.

Dr. MARTIN (*Bull. gen. de Thérapeut.*) states that if the breasts of a nursing woman be covered with parsley leaves freshly pulled, the application being renewed several times a day, as quickly as the leaves fade, the milk will soon cease to appear. This is an application which may be used when it is impossible to give purgatives or other remedies internally.—*Med. & Surg. Reporter.*

Bladders of Ice in Mammary Abscess.

Dr. HIRAM CORSON (*Am. Jour. Obstet.*) speaks in high praise of applications of ice in bladders to inflamed mammae to prevent abscess, or even if abscesses have formed, to limit the destructive process. He has followed this practice for twenty-seven years, and in no instance, if suppuration has not already taken place, has he failed to disperse the inflammation at the same time that he brought comfort to the patient.—*Pac. Med. & Surg. Jour.*

The Alum Plug in Uterine Hemorrhage.

Dr. R. W. GRISWOLD, Connecticut, says:

For the last twenty years my reliance has been on a junk of alum in the vagina. If this is not at hand I take the next best thing that is; but a junk of alum is a part of the contents of my medicine box. It is of the size of a large hen's egg, ovoid in shape, and generally left a little ragged, though without sharp points. Around the middle is cut a groove, about which is tied a bit of

strong but not large twine, leaving the ends so that they can hang out of the vagina. This treatment is easy, speedy, and effectual against further hemorrhage. It has never failed me, and I leave a patient with a feeling that she is safe for the next twelve or fifteen hours, so far as danger from further bleeding is concerned. And I may add that I have never had any unfavorable effects follow its use in any one of the scores of cases in which it has been employed—no fevers, no septicemia, no deaths, no anything onward—and I have never had occasion to use it the second time in any one case.—*Western Lancet, San Francisco.*

Nitrite of Amyl.

HERN (*Revue Médicale*) reports a case of post-partum hemorrhage immediately arrested by the inhalation of five drops of nitrite of amyl. He attributes this action to congestion of the head. It will act as hot water on the head, and will prevent anæmia of the nervous centre.

False Pregnancy at Term.

Dr. RENDU (*Le Concours Médical*) reports the case of a well built, hitherto healthy girl of seventeen, whose menses ceased on the fifteenth of February, and during the succeeding four months the usual symptoms of pregnancy, extending even to apparent movements of the child, made their appearance. The patient being apparently in labor about the nineteenth of November, sent for a midwife. The midwife obtained assistance from the midwifery clinic of Lyons, whereupon it was found that the case was one of spurious pregnancy. This being communicated to the patient, the symptoms of pregnancy disappeared and she immediately began to recover.—*Chicago Med. Review.*

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Sponge Tents.

DR. ALBERT H. SMITH (*Obstet. Gazette*): It is not necessary to dilate upon the necessity of mechanical dilators for the neck of the uterus, both as a means of diagnosis and as an important therapeutic measure.

The original sponge tents were made from a flat piece of sponge saturated with wax and pressed flat between pieces of marble. This form of tent is comparatively useless, as it expands in one direction only. The first suggestion of the present form was, I think, by Dr. Sims in his work on uterine surgery. His method consisted in immersing a conical piece of sponge in a strong mucilage of gum arabic, impaling it upon a wire skewer, and winding it tightly with a cord, after which it was hung up to dry, when the cord and skewer were withdrawn, and the tent smoothed with sand-paper. If the cord was wound on the sponge with sufficient tightness to give the test useful expanding power, great difficulty was experienced in withdrawing the stylet. I was led to make a few changes in the method, and now employ a cylindrical piece of sponge, which is saturated with water only, and, without any stylet, is wound with a piece of fishing line, to which a six-pound weight is attached; this compresses it thoroughly, and its form is easily given by the fingers during the process of rolling. The surface should be made as smooth as possible by means of sand-paper.

The tent should be of uniform size from end to end. If it is conical the

tent is introduced as far as possible, but only the small part, without much dilating power, enters the internal os, and it is not unfrequently withdrawn unexpanded, while the external os and the cavity of the cervix is widely dilated. The sponge selected should be strong and fine. I have seen tents made from coarse rotten material, which would break during the extraction, leaving portions within the cavity of the uterus.

The introduction of medicating materials into an internal cavity of the tent is objectionable, as they usually corrode the sponge; and the space and loose winding necessary to allow the removal of the stylet, reduce materially the dilating power. The curved shape is useless, as the uterus can be straightened before the insertion of the tent, and less force is needed for the insertion of a straight one.

To prepare the uterus for the introduction of a tent: First use a dilator of soft metal or a graduated wax bougie to straighten the cervix and measure the length and calibre of the uterine cavity, noting tortuosities, etc.; then rapidly introduce the largest tent possible, having first coated it with an enameling material, as soap, and immersed it in a base of salicylic acid in fine powder, which is to be rubbed in thoroughly to form an antiseptic paste over the tent.

A sponge tent thus prepared may be allowed to remain in situ for forty-eight hours without developing any unpleasant odor, unless there is breaking down tissue which may overpower the disinfecting powers of the acid.

For ease in inserting I have had constructed a peculiar powerful forceps to

hold the tent clamped tightly and enable the operator to pass it rapidly to its position. Hot water injections after the tent is in position will expand the sponge rapidly and fix it in about a minute. If pain follows the insertion, it can be controlled by opium suppositories.

Time of Removal.—If the tent is removed at the end of twenty-four hours, it will cause hemorrhage, because the spongioles have buried themselves into the cervical tissues, which grasp it tightly, and a forcible extraction will drag away portions of the uterine tissue and leave a raw and absorbing surface. But at the end of forty-eight hours the tent comes away easily without any bleeding. The contractile power of the uterus still remains at the end of twenty-four hours, and the presence of a finger or application in the cavity of the uterus causes rapid contraction. At the end of forty-eight hours the uterus is paralyzed, all pain has ceased, and local irritability is less. When the tent is removed, wash out the cavity of the uterus with tepid, salicylated water, and if necessary introduce a second tent.

Among the advantages of the sponge tent are its slowness of dilatation—not slowness of expansibility. The power of the laminaria tent is greater as a dilator, but it will slip from the uterus as soon as it has ceased expanding, while the sponge tent will remain as long as it is wanted to. The sponge has also a disintegrating power over morbid surfaces. The healthy tissue will contract again, but diseased structures will not contract, but slough off, their vitality being destroyed. The sponge being porous, discharges will pass through it.

The usefulness of the sponge tent is for both exploratory and therapeutic purposes. It causes removal, there is less tendency to contraction, and thus

more satisfactory for exploratory preparation. The sponge has a stimulant effect on the uterine parenchyma, and in cases of chronic metritis and hyperplastic enlargement it will cause a reduction of bulk.

In one case, after the prolonged use of internal applications of iodine, nitric acid, etc., the repeated use of sponge tents resulted in a complete restoration to the natural size.

In one case, years ago, I introduced a sponge tent, in my office, and allowed the woman *to walk home and keep about her daily duties*. The menstrual flow came on two days later, entirely without pain, for the first time in the patient's experience; the flow escaped through the sponge, and the latter was then removed. Conception occurred before the next menstrual period. The sponge tent is also the safest agent for the destruction of granular growths of the endometrium. A patient had been bleeding profusely at every period for three years; supposing a polypus to be the cause, a sponge tent was introduced to secure dilatation; a finger was introduced into the uterus, but finding no polypus, more tents were passed to the fundus; fungoid growths of the endometrium were broken up by the tents. I was disappointed in my expectations of finding and removing the supposed cause of the hemorrhages, but was agreeably surprised to find the patient remain well after the uterus contracted.

Another patient was sent to me from Boston, for diagnosis only. I obtained permission to use a tent for exploratory purposes. I dilated the uterus with the largest sponge tent, passed to the fundus, introduced my finger and found fungosities on the anterior wall; but the means intended for exploration resulted in a cure.

In a case of polypoid pediculated

growths, I at once dilated with sponge tents after the use of the wax bougie; the finger found a pediculated growth as large as a hen's egg, but the tent had disintegrated it; it could be removed by the finger without instrumental aid.

[Dr. Smith's preparation of tents by coating with soap and salicylic acid is valuable. We have for years used soap as a lubricator, and know it to be the best. The addition of the acid is no doubt an improvement. We take strong exceptions to the doctor's habit of leaving a tent in place forty-eight or even twenty-four hours. To effect dilatation a much shorter time only is required. A good tent will expand to its utmost in six or eight hours. The therapeutic effects which the doctor claims for the tent may require a longer time, but there certainly is danger of exciting an acute inflammation while trying to cure some other disease, by leaving a sponge tent in the uterus for forty-eight hours. A sponge tent acts as an irritant, like any other foreign body, in the tissues, and will certainly produce inflammation unless the uterus happens to be unusually tolerant.

The doctor took an unwarranted risk when he introduced a tent in his office, "and allowed the woman to walk home and keep about her daily duties." Such treatment has proved disastrous a sufficient number of times to make most men avoid it.

That "the sponge tent is also the safest agent for the destruction of granular growths of the endometrium," will be doubted by the majority of Gynecologists who use the curet for that purpose.] A. J. C. S.

Ovariectomy.

Prof. WM. GOODELL, M. D. (*N. C. Med. Journal*), presented a case successfully treated and made the following re-

marks: Where the adhesions are simply parietal we do not consider the case difficult, but when the cyst is fastened to the bladder, the womb, or the intestines, we have a very serious matter in releasing them, and sometimes we are unable to do so.

In this case there were two firm adhesions to the omentum. These were tied and divided. Then there were very firm adhesions to the abdomen, and in some places these could not be broken up and portions of the cyst had to be allowed to remain. The bleeding from these surfaces could not be entirely checked. There was a large surface up towards the liver, where there were eighteen or twenty little bleeding vessels. We tried to stop the oozing but could not succeed. I therefore put in a drainage tube. This was nothing more than a glass tube with perforations at the sides. The object is to allow the blood that oozes out to escape. The fear being that the blood, if allowed to remain, may become changed and cause the woman to die from septicæmia.

There is a diversity of opinion among ovariectomists in regard to the use of the drainage tube. Dr. Keith, of Edinburgh, invariably uses the drainage tube when there is much oozing. Dr. Wells, who has operated some 1,000 times, does not use it. Dr. Thornton does not use it, and he argues that with the use of carbolic acid and the spray, there is no danger of septic poisoning, and that this large peritoneal surface, which is a good absorber, will take up the blood that oozes into the cavity. Dr. Keith has given up the spray because he thinks that some of his patients were poisoned by it. The carbolic acid causing a nephritis. I still adhere to the spray and intend to do so until I have good reason for giving it up.

There was no need of a drainage tube

in this case, for during the first twenty-four hours only two ounces of blood escaped. The next day there was a teaspoonful. On the third day the tube was removed. Immediately after the wound was dressed, a large layer of cotton was placed over the abdomen and firm pressure made. This stopped the bleeding. She has not had a single bad symptom.

She is going to leave the hospital on Thursday, but she will have to wear a binder made with a gore for the next six months, in order to prevent any tendency to the formation of hernia. The objections to the drainage tube are, firstly, that it is a foreign body, and secondly, that it leaves a weakened cicatrix, at which point there is a liability to hernia.

[It appears to us that the drainage tube was needed in this case. The two ounces of blood removed by it might have caused death if permitted to remain in the peritoneal cavity.] A. J. C. S.

Death after Ovariectomy, Due to Preliminary Tapping.

LAWSON TAIT, F.R.C.S. (*Medical Record*): In the last series of one hundred operations which I have performed for the removal of ovarian cystoma, there have been three deaths, and in all of these cases the patients had been previously tapped. The deaths were all of the same kind, and were due to the same cause—heart-clot; and they would, I feel sure, most certainly not have occurred but for the tapping. With such an experience, I think it quite time that a strong opinion was pronounced against the practice of tapping ovarian tumors in all cases where removal of the disease is possible.

Whilst the mortality of ovariectomy with the clamp was *twenty-five per cent.*, this was the correct thing to do, but now that the mortality is only *three or*

four per cent., especially when the whole of that very small death-rate seems to be due entirely to conditions produced by *delaying* the operation, we must reverse our practice and perform ovariotomy in an early stage of the disease. If my operations were confined to cases which had *never been tapped*, I think I should have no mortality at all, or, at any rate, less than *one per cent.*

In a case in point, to which I will allude, was one in which neither the age of the patient nor the character of the tumor were such as to warrant an unfavorable prognosis, but I told my friend who sent me the case that she would probably die of heart-clot in thirty or forty hours after the operation, because she had been tapped a great many times. On the day of the operation she was of immense girth, yet sixty pints of fluid had been taken from her only a few days before.

The fluid was intensely albuminous, that is to say, it was made viscid by a large amount of one or more of those mysterious inconstant coagulable substances found in ovarian and ascitic fluid. I have made prolonged researches on the nature of these substances, and so far I have found *no two exactly alike*, and therefore I looked upon it as hopeless to expect that we shall ever be able to reduce them to order or to a satisfactory nomenclature. It is perfectly certain that the abstraction of these albuminous substances in large quantities deprives the blood of some very important item of its constitution, and it is no less certain that when the blood has been robbed of these substances the rest of its constituents, or some of them, have a tendency to coagulate in a most unusual way. The patient of whose case I am speaking did not look anæmic, and she was not very much emaciated, but within three years she had had at

least seventy gallons of fluid, with about eight per cent. of solid matter in it, removed by tapping.

Unfortunately the result of the operation fulfilled my prediction. In a few hours the swelling of her legs, the difficulty in breathing, the slight delirium, the rapid rising of the pulse and its speedy disappearance from the extremities, showed me that my previous experiences were being repeated. From the point of ligature in the stump a firm, colorless clot began to grow. It gradually occupied the whole venous system, finishing its work in thirty-six hours. Such an ending I have never seen in any case in which there had been no repeated previous tapping.

I conclude from this and from the fact that all the three deaths in my last hundred cases have been of exactly the same kind, that ovarian tumors should never be tapped until it has been ascertained that they cannot be removed.

If a patient is once tapped she insists on its repetition, as long as she gets a few weeks' relief from it, whereas, if she had the tumor removed in an early stage, she would have permanent relief without risk. The first tapping is therefore the step that is to be avoided, for not only is it risky in itself—far more risky, I believe, than the removal of an untapped ovarian tumor—but it complicates the subsequent operation in a very fatal manner.

Diagnosis of Ovarian Tumors.

Dr. A. MACDONALD (*Edinburgh Medical Journal*):

1. *Pregnancy*.—The possibility of pregnancy, the signs and symptoms of pregnancy, and waiting if in doubt, place the diagnosis beyond possible mistake, with a fair measure of care.

2. *Fibroid*.—A large fibroid with solid walls, leading to general enlargement of

the uterus, is easily diagnosed. The increased length which the sound enters, the fact that the uterus moves with the sound, the peculiar feel of the uterus, and the nearly constant menorrhagia, suffice to keep the diagnosis correct. It is quite common to hear a bruit in a case of uterine fibroid; only in vascular sarcomata is such audible if the tumor is ovarian. But much greater difficulty is experienced in cases of fibro-cystic tumors connected to the uterus, with or without pedicle. In that case we must try to ascertain whether the tumor is connected or disconnected with the uterus. Then the cyst of a fibro-cystic tumor may be tapped, when we expect to find only a thin fluid of great density, with some blood-corpuscles, and possibly some non-striped muscular fibres. But in those cases it is often found that only an exploratory incision can determine the diagnosis with accuracy.

3. *Renal Cysts* begin below the false ribs and extend downward and forward. They have a line of resonance between them and the liver, due to the transverse colon, which is of value, as showing they are not of hepatic origin, and when aspirated they contain urea. Usually accompanying such there are urinary symptoms, but not always.

4. *Ascites* exhibits the characters of free motion of fluid in an imperfectly filled cavity. Accordingly, when the patient lies on her back the abdomen is flattened anteriorly, the flanks give a dull note, and there is clearness round and above the umbilicus. With change of the patient's position the areas of resonance alter. Thus, if the patient is turned on her left side, the right flank gives a clear note, and *vice versa*. In case of tapping an ascites the thick gelatinous fluid characteristic of ovarian tumor is never obtained.

5. *Hydatid Cyst of the Liver*.—In this

case, the tumor grows from the liver, distending first the distance between the ensiform cartilage and the umbilicus, the reverse of an ovarian cyst. Again, tapping and discovering acephalocysts in the fluid is convincing evidence of the true nature of the tumor.

6. *Hysterical Abdominal Distention*, commonly known as spurious pregnancy, need deceive no one, as the percussion is uniformly resonant, and the tumor disappears under chloroform.—*Med. & Surg. Reporter*.

Rules for Introducing the Uterine Sound.

DR. CAMERON (*Glasgow Med. Journal*):

It has been recommended in special cases; but it is better to avoid any examination during menstruation, and in no case should the sound be passed without previously having made a careful bimanual examination.

To introduce the uterine sound, place the patient as in passing the speculum and pass two fingers of the right hand, viz., the index and middle up to the cervix, with the knuckles toward the pubes, and in the groove formed by the fingers glide the instrument along, keeping the concave surface directed backward. Never forget to have the sound warmed previous to its introduction.

If the passage is straight, as in females who have never had children, the index finger will be sufficient to guide the sound. If the os is directed downward and forward, the instrument is passed into the cavity without rotating the handle; if the os is, however, directed downward and backward, the instrument is only allowed to enter the external os, and then the handle is turned so that the point of the sound may be directed upward and forward.

If there be any difficulty in making the instrument enter, this is often overcome by slipping the point of the instrument from the finger tip into the os.—*Can. Med. Record*.

[American gynecologists generally pass the sound through a Sims speculum, the easiest way of doing so. In measuring the size of the uterus, a graduated sound with a slide attachment is employed in this country.] A. J. C. S.

Ablation of Fibroid Tumors of the Uterus.

At the Académie de Médecine M. Guéniot communicated some observations on the different methods employed in the ablation of fibroid tumors of the uterus. He would give the preference to excision by the aid of the constrictor or *serre-nœud*, on account of its simplicity and its security. He considered it even superior to Chassaignac's *écraseur*, in that it can be applied with greater facility, and that it can attain polypi situated on the fundus of the uterus without necessitating a previous traction on the organ. The operation is as bloodless as when the *écraseur* is employed, and the pedicle is cleanly cut across.—*Med. Times*.

Carcinoma of the Neck of the Womb.

DR. WILLIAM GOODELL (*Med. & Surg. Reporter*) in a clinical lecture on this subject said: In operations around the womb vinegar is one of the *best hæmostatics*. In cases where union by *first intention* is desired, I should not care to use it; but where you have bleeding, and wish to check it, you should use vinegar. If you inject Mensel's solution into the vagina, its astringency is so great that it contracts the vagina to such an extent that you find great difficulty in your further operations.

This patient is thirty years old, married, and has had several children. I want to impress one thing on your minds; it is this: that carcinoma of the neck of the womb almost never occurs in a sterile woman. The inference therefore is, that carcinoma of the neck of the womb always occurs at the seat of a laceration of the cervix. On the other hand, when you come to cancer of the body of the womb, sarcoma, spindle, and round-celled, cylindrical epithelioma, if you choose, these, which are very rare, usually occur in old maids and married women who have never borne children.

We have here the typical leaden complexion which is supposed to be pathognomonic of cancer. After the operation that will disappear. This color is, I think, due to a sort of slow septicæmia.

I shall now begin and rapidly break up these granulations with my finger.

The whole anterior neck of this womb is gone, and I have to be very careful not to get into the bladder. I shall now use this instrument. It is a gouge forceps, devised by Dr. Remey, of Cincinnati; the object is to have as little hemorrhage as possible; it is a very good instrument. The points which bleed are right in the cancerous mass, but after this has been removed the bleeding becomes less, and then it comes from the edges of the cervix, where the mucous membrane runs on the outside of the neck. In order to control this hemorrhage I employ pressure forceps, when necessary.

This operation is an exceedingly successful one, as a make-shift. This woman has been loosing a great deal of blood; she has had considerable pain, but not the agonizing pain that she will have in the course of a year. In cancer of the neck of the womb pain does not

exist to any great extent, unless the disease has passed the internal os. This absence of pain often misleads physicians. When the disease passes the internal os the sufferings are terrible. There is nothing which equals the suffering of a woman lingering on with the disease involving the uterine cavity.

I have now removed every portion of the cervix, and have a funnel-shaped opening leading up to the internal os. As I have said, the results of this operation are very good. The woman's life will be prolonged. Some patients will die from exhaustion; one patient died from the disease involving the stomach, and others die from involvement of the pelvic organs.

The whole anterior part of the neck is not only gone, but I am directly upon the wall of the bladder, and the connective tissues lying below it. There is a space about the size of a silver dollar, where the womb is entirely gone. I am, therefore, a little cautious in what I do in that direction.

I shall now apply the cautery (Paque-lin's). In a former case I applied this cautery and the patient got perfectly well, or rather it all healed excepting a spot about the size of a ten cent piece. On a future day I applied nitric acid without doing any good. I then concluded to apply the hot iron, without saying anything to her about it. I did so, but she never winced, although she wondered where the smell of burnt flesh came from, and thought that something must have burned in the kitchen. You can, in almost all cases (there are some exceptions, to which I shall allude) pass the hot iron into the cervix without giving as much pain as by the application of nitrate of silver; but, on the other hand, just as we have painful hair (I remember seeing in my young days, a case of *plica polonica*), as we have cartilage

sensitive, which is usually not so, so we do occasionally meet with a case of sensitive cervix.

Let me say one word about taking off the neck of the womb. Your books tell you to take off the neck of the womb with the hot wire, in preference to the cold wire, but I have given up the hot wire, for I have had secondary hemorrhage of the most frightful character after its use.

I do not like to tampon the vagina after this operation, for it keeps all the discharges in the vagina, but if I performed this operation at a private house, I should dip a sponge in vinegar, pass it into this cavity and leave it there for forty-eight hours, because the sponge has meshes, and into these meshes will dip the inequalities of the cervix. The cervix is going to contract, and every inequality of the cervix is going to find a corresponding depression in the sponge. If I remove the sponge in the twenty-four hours, I am going to tear away some of the surface, and may get hemorrhage. I, therefore, leave it until pus has formed. Suppuration begins in twenty-four hours, and in forty-eight hours has advanced sufficiently to allow the removal of the sponge. If at the expiration of this time I find, when I catch the string fastened to the sponge, that it is not going to come away with ease, I leave it for twelve hours longer. The danger from septicæmia is not very great, for the whole surface has been seared with the hot iron, all the blood vessels and lymphatics have been sealed, and a clot has formed in their mouths.

She will begin to smell very badly after forty-eight hours; the vagina will be syringed several times a day with a carbolic acid solution. After the sponge has been removed, it will be syringed at least twice a day. I shall give her a suppository of one grain of opium when

she is taken to the ward. The pain of which she will complain will be due to the pressure of the speculum on the coccyx. I always begin to give quinine after the operation. I try to cinchonize the patient within twenty-four hours, so that she will have buzzing in the ears. I give quinine because, in the first place, it is an antipyretic; secondly, it contracts the womb, so that the area of absorption is diminished; and, thirdly, it is an antiseptic.

These cases are to be undertaken without any delay. Just as soon as you have diagnosed a carcinoma propose the operation.

One word in regard to the diagnosis. I do not think that any student who leaves this University will, when he lays his finger on a carcinoma, ever mistake it for anything else; but he may, perhaps, put his finger on a polypus, or a fibroid tumor projecting from the os, or on a bad laceration, and think that he has a cancer. I thought that it was impossible to blunder about a carcinoma; but last summer I had a bad case of laceration of the cervix, which the woman said was done when a child only five months old was born. The tissues were so everted and there were such friable granulations, that I could not at first decide whether or not it was cancerous. I examined the woman closely, and determined that cancer had not occurred. I then proceeded with the operation, which resulted in a perfect cure.

One diagnostic point is that cancer always has friable vegetations, and if it is an excavating cancer (usually they are excavating) you can feel a sharp edge around this cavity filled with friable vegetations. I compare it to the crater of a volcano. When the carcinoma projects into the vagina, you distinguish it from polypus and fibroid tumor by finding that in the latter condition the

tumor projects through the mouth of the womb, and you are able to distinguish the neck of the womb, but in the former the cancer forms a part of the neck of the womb, and cannot be separated from it.*

Uterine Displacements.

Dr. F. A. CASTLE, in a paper read before the New York Academy of Medicine and reported in *Medical Record*, spoke of over-distention of the abdomen with flatus as one of the causes of prolapsus uteri and other forms of uterine malposition.

For some time he had been led to regard this factor as an important one in the etiology of prolapsus, and, in the treatment of this form of displacement particularly, he regarded it as essential to resort to measures calculated to correct indigestion and keep the alimentary canal free from flatulence, as well as to use mechanical supports for the uterus. He had not seen any mention made of this etiological factor in any of the books on uterine diseases.

With regard to retroflexion or retroversion and fixation of the fundus to the anterior wall of the rectum by adhesion and interference with the function of the bowel, he had noticed one symptom of which he had not seen any mention made, namely, hemorrhage not due to hemorrhoids. He had been in the habit of treating such cases by a modification of Dr. Campbell's pneumatic method, and, in addition to distending the vagina, had at the same time distended the rectum with air. His results had been, by the use of the combined vaginal and rectal distention, that defecation had been rendered more satisfactory, and the hemorrhage had been diminished in severity. It was not to be expected that retroversion of the uterus would be cured by this method.

[Dr. Castle has done well in calling attention to intestinal flatus as a cause of uterine displacements. It appears to be rational and certainly leads to good treatment. We cannot say so much for his adoption of Dr. Campbell's pneumatic method of restoring the displaced uterus. It is to say the least a very *disagreeable* kind of treatment for a patient to practice upon herself, and Dr. Castle's modification makes it more so. More than that it is not as efficient as the method recommended long ago by J. Marion Sims.] A. J. C. S.

Treatment of Purulent Endometritis with Ulceration of the Cervix.

Dr. CHÉRON (*Le Progres Médicale*) remarks that patients suffering from a purulent discharge, the result of endometritis, with or without ulceration, are frequently unable to bear injections of such substances as coal-tar, which are particularly apt to dry the secretion. In such cases Dr. Chéron finds it useful to employ the following solution of tannic acid in glycerin:

Tannic acid, 60 grams; Sydenham's laudanum, 10 grams; neutral glycerin, 350 grams.

Dissolve the tannic acid in the glycerin by means of heat, without using water, then filter and add the laudanum, viz., one or two dessert-spoonfuls to be added to a litre of warm water; injections to be made morning and evening. The effect of the injections is to cause a rapid diminution of the purulent secretion. The pruritus and irritation of the external parts disappear, whilst the sensation of weight and pain are less felt after a few days. If there be no ulceration, the dose of laudanum may be increased to twenty, or even to thirty grams, without inconvenience.—*Med. Times*.

DISEASES OF CHILDREN.

Diarrhœa in Infants.

Prof. PLANT, Syracuse (*Cincinnati Med. News*): In all forms of diarrhœa the diet and drink should receive attention. I doubt if the fact is sufficiently recognized that in very many cases of diarrhœa the trouble is primarily at the stomach. The food, disproportioned in quality or quantity to the ability of that viscus, is but partially elaborated. It undergoes fermentation instead of proper digestion. As a consequence, an acrid chyme passes into the intestine, irritating its mucous membrane and increasing peristaltic action. Fresh milk from the cow agrees with most infants after weaning. I have also used condensed milk (Borden's) in the proportion of one part to ten or fifteen of water, and have been satisfied with it. Hard curds, if formed, may be corrected with the addition of lime water, a quarter or a third of the bulk; or bicarbonate of soda (fifteen to forty-five grains) to the pint of milk. If the stools are flecked with bits of undigested casein, the stomach has lagged in its work, and I use saccharated pepsin, about one gramme (fifteen grains) to the half pint. Both soda and pepsin may be added in obstinate cases to the milk with the apparent effect of stopping the vomiting and lessening the diarrhœa. In some cases, however, milk, modify it as you may, offends the stomach and increases diarrhœa. In such you will do well to feed the child for a time with animal broth—veal, lamb, or beef—or with one of the artificial foods, as Mellin's, Horlick's, Ridge's, or Nestle's.

In no disease is the desire or need of water so urgent as in profuse diarrhœa, it is harmful to withhold it. You may give cold water in all forms of diarrhœa.

Bear in mind that a simple diarrhœa in the child, is often the result of over-

feeding. In such cases a restricted diet or abstinence from food for a day may effect a cure without medicine.

Sometimes its advantage to give an efficient laxative to carry away any peccant matter which the bowel may contain. For this purpose I know of nothing better than castor-oil. Its tendency to cause griping pain may be obviated by giving with it or after it a little paregoric or laudanum—from twenty to forty drops of the former, from one-half to one drop of the latter. A combination of equal parts of rhubarb and carbonate of magnesia answers the same purpose. If there appears to be a deficiency of the biliary secretion, if the skin is sallow and the tongue coated, you will do well to give one to two grains of hydrargyrum cum creta.

Superacidity characterizes most cases of infantile diarrhœa. For this reason something like the following laxative and corrective, I give:

℞. Pulv. rhei., sodæ bicarb., āā gr. xv.—1.00 gm.; syrupi simp., $\frac{3}{4}$ —20.00 fl. gm.; aquæ menth. pip., $\frac{3}{4}$ jss.—45.00 fl. gm. M.

S.—A teaspoonful or more.

Do not carry the laxative treatment too far, especially with young infants, in very warm weather. I have used the following, with much satisfaction, in cases where the stomach digestion appeared to be at fault:

℞. Pepsine sach., gr. xxx.—2.00 gm.; bismuth subnit., $\frac{3}{4}$ jss.—6.00 gm.; tinct. opii., gtt. xxiv.—0.70 fl. gm.; syrupi simp., $\frac{3}{4}$ j.—40.00 fl. gm.; elix. simp., aquæ, āā $\frac{3}{4}$ ij.—60.00 fl. gm. M.

Teaspoonful every three or four hours if awake.

I often use, in children's diarrhœa, the following:

℞. Ipecac. et opii pulv., gr. vijss.—0.50 gm.; bismuth subnit., gr. xlv.—3.00 gm.; aquæ, $\frac{3}{4}$ ij.—60.00 fl. gm.

S.—Stir and give a teaspoonful once in three to four hours if not asleep.

You may increase the stringency of these formulæ by the addition of tincture of kino or catechu or extract of log-wood.

In the treatment of *persistent* diarrhœa with *inflammation*, strive, if possible, to remove the cause or to escape from it. If the infant is living in this city, and is hand-fed with the milk from the carts, send it to the hills south of us, and keep it on a farm till October. Unfortunately the disease prevails most among the poor, who cannot afford the expense of removal. In such cases secure the best ventilation possible. If living in a damp basement, insist on a change of quarters. The remedies are much the same as those recommended for the milder form. Opium is by far the most valuable. It checks the action of the bowels; it promotes the action of the skin; it relieves pain, it secures rest, and checks the rapid waste. In some form it is an ingredient of nearly all our prescriptions for this kind of intestinal flux. The foregoing formulæ may be employed, or the following from the excellent work of Prof. J. Lewis Smith:

R. Tinct. opii., gtt. xvj.—0.50 fl. gm.; bismuthi subnit., 3 ij.—8.00 gm.; misturæ cretæ., 3 ij.—60.00 fl. gm.

Sig.—A teaspoonful every three hours.

If vomiting prevents successful medication by the mouth, we may have recourse to the rectum. An enema of from one to three drops of laudanum for an infant of one year, in a teaspoonful of mucilage or hydrated starch, will usually be retained. Opiate suppositories answer the same purpose. For infants they may be made in urethral molds. From one twenty-fourth to one-eighth of a grain of opium may be used for a child one year old.

Next to the diarrhœa the most trouble-

some symptom is vomiting. The preparations before mentioned that contain bismuth are sometimes effectual. Lime water may be added to the food or given by itself. Calomel in minute doses (one-tenth of a grain), placed on the tongue, repeated once an hour, sometimes acts magically. Quarter or half-drop doses of wine of ipecac, or correspondingly small doses of nux vomica will sometimes succeed. When all ordinary diet has failed to remain upon the stomach, raw meat finely chopped and seasoned has been given with success.

In this form of diarrhœa you will do well to begin early the use of stimulants. Do not wait till vitality is exhausted before using brandy, or bourbon, or champagne. Given *with the food*, stimulants seem to render the stomach more retentive.

The infant should be put once or twice daily into a warm bath. Aside from its effect in equalizing the circulation, and so relieving intestinal hyperemia, it is an admirable measure for inducing a tranquil and restful sleep.

Outside applications are useful, nothing is better than a thin linseed poultice with a little mustard—say one part to twelve of flax-seed. This, covered with oil-silk, may be applied to the whole abdomen.

In the treatment of the dysenteric form of bowel-trouble medication per rectum is of *peculiar* value. Nothing relieves the pain and distressing tenesmus like opiate injections and suppositories given as before advised. The little patient should be kept at rest and recumbent. Prolapse of the rectum is more apt to attend this form than any of the others. Beyond prompt reduction by gentle pressure no treatment is necessary.

In *cholera infantum* opium is our sheet-anchor. It must be given in decided

doses, yet circumspectly, lest we induce a fatal narcotism. Prof. Smith gives a formula which I think well of in this connection :

R. Tinct., opii., gtt. xvj.—0.50 fl. gm.; spts. amm. aromat., 3 ss.—2.00—4.00 fl. gm.; bismuth subnit., 3 ij.—8.00 gm.; syrupi simplicis, aquæ, āā 3 j.—30.00 fl. gm. M.

Sig.—A teaspoonful once in two or three hours to a child one year old. If less, reduce the dose. Suspend if drowsy.

I have much faith in the efficacy of the warm bath often repeated. Stimulants are necessary, and should be freely given from the outset. Champagne is one of the best in this form of diarrhœa.

If cerebral symptoms—such as rolling of the head, clutching at the hair, and spells of hard crying, alternating with drowsiness—appear, look upon these phenomena as denoting *cerebral anemia* consequent upon the rapid drain from the blood, and treat accordingly.

Carbolic Acid in Whooping Cough.

Dr. J. BAUGH, of London (*Canada Lancet*): A few days since I had several patients suffering with whooping cough, and, having administered the usual remedies without getting the least benefit, I commenced giving carbolic acid and glycerine in small doses, repeated every hour. I am glad to say the results were very satisfactory. The paroxysms of coughing and the vomiting, which in some cases were very severe and frequent, were reduced almost to a minimum in less than twenty-four hours. For a child three years old I give the following :

R. Acid carbolic, gr. iv., 0.24 fl. gm.; glycerini, 3 jss., 6.00 fl. gm.; syr. simp., 3 iv., 16.00 fl. gm.; aquæ, ad, 3 ij., 60.00 fl. gm.

M. Sig.—A teaspoonful every hour.

Poisoning by Winslow's Soothing Syrup.

In the *Sanitary News*, there is a report of another death of a child eight months old, from the administration of a teaspoonful of "Mrs. Winslow's Soothing Syrup," the symptoms of poisoning by morphia being well marked. Analyses of this dangerous nostrum have shown that each ounce of the syrup contains *one grain* of morphia, so the dose, according to the directions on the bottle, for a child eight months old, contained *one-eighth* of a grain of morphia. It is about time that legal proceedings should prohibit the sale of such dangerous compounds, when advertised as inoffensive.—*Med. News*.

Method of Introducing Food and Medicine by the Nostrils.

M. FERNET (*Revue de Thérap.*) wishes to popularize the method of introducing liquid of semi-solid elements, and certain drugs, by the nostrils. The author has seen it employed successfully in newly-born infants too weak to take the breast or milk from a spoon. He proceeds as follows: The patient being laid on his back, a little raised, the end of a spoon, or, better, the spout of a close vessel is brought near to one nostril, and its contents poured in gently at intervals. The liquid slides over the floor of the nasal fossæ and the roof of the palate, and reaches the pharynx, where it induces movements of regular deglutition. If the operation be well done the liquid never returns by the other nostril. This method may be applied in certain cases of apoplectic coma, when the patient can not drink for three or four days successively, in the tuberculous meningitis of children, etc.—*London Med. Record*.

Membranous Croup and Laryngeal Diphtheria.

Dr. HUGO ENGEL (*Med. and Surg. Rep.*) gives the following points of difference :

Membranous Croup.

Is due to exposure to cold.

No period of incubation.

Is a local disease, consisting of an inflammation of the mucous membrane of the larynx with exudation of false membranes.

The false membranes, beginning in the larynx, may extend from there to the pharynx.

Affects children only.

Begins mostly suddenly, at midnight, with croupy cough, &c.

The child loses its strength only after frequent vomiting, and towards the close of the disease.

Never any constitutional symptoms except high fever (symptomatic of the violent laryngeal inflammation), and near death, symptoms due to want of oxygen.

Never any complications.

Albumen in the urine only after dyspnoea has become great.

Never enlargement of glands.

Never contagious.

Never followed by any sequelæ.

Rapid convalescence.

False membranes soluble in potash solution, hardening in sulphuric acid.

Membranes consisting of new formation of cells.

Laryngeal Diphtheria.

Due to a specific poison.

Period of incubation one to five days.

Is a constitutional disease, where bacteriæ are deposited, and form false membranes on the mucous membrane of the larynx.

The false membranes exist at the beginning of the disease in the pharynx, and extend from there down to the larynx, and frequently up into the nose.

Attacks adults also.

The child has been ailing three to five days before croupy symptoms appear.

The child becomes weak from the very beginning, and loses strength rapidly even before appearance of croupy symptoms.

Constitutional symptoms from very beginning, moderate fever long before laryngeal symptoms, and child dies often from septicæmia before death by suffocation sets in.

Often nasal diphtheria, sometimes endocarditis, always septicæmia.

Albumen in the urine from the very beginning of graver symptoms.

Enlargement of glands from very beginning, and never absent.

Very contagious.

Frequently followed by local and general paralysis.

Very slow and tedious convalescence.

False membranes soluble in sulphuric acid, hardening in potash solution.

Membranes consisting of masses of bacteriæ and cells.

OBSTETRICS.**Basilysis.**

About two years ago Prof. A. R. Simpson, of Edinburgh, proposed a method of comminuting the basis

cranii in craniotomy operations. He exhibited before the Edinburgh Obstetrical Society an instrument for this purpose which he termed the basilyst. The instrument is not unlike Thomas' perforator in appearance. It terminates in

a gimlet-like extremity and assures the perforating of the cranial vault as well as "basilysis."

It consists, however, of two lateral halves which may be separated by compressing the lever-like handles after the point has been fixed in the bone. Thus the base as well as the vault of the cranium may be broken up.

Prof. Simpson reports a case of craniotomy in the March number of the *Edinburgh Medical Journal* in which he used this instrument for the first time. The dissolution of the cranial base was easily and safely effected, and the head was eventually expelled by the uterine action alone.

Funic Hemorrhage During Labor.

DR. CROOM (*Med. Press and Circular*) read a paper on this subject before the Edinburgh Obstetrical Society.

After discussing that form which occurred through sudden delivery and rupture of the cord, in which hemorrhage is always very slight, he went on to discuss, with illustrative cases, that form of funic hemorrhage which arose during labor from a faulty insertion of the cord. He pointed out the rarity of the condition, and after disposing of the literature of the subject, went into a description of insertio-valamentosa, the condition usually associated with this form of hemorrhage. He showed three sources.

1. Where the hemorrhage comes from the funic vessels, passing over the lower segment of the membranes to a placenta normally situate.

2. Vessels inserted marginally into a placenta situate low down.

3. From vasa aberrantia. The diagnosis and treatment were discussed at length, the latter mainly consisting in the preservation of the membranes, and immediate delivery on their rupture. — *Obstet. Gazette.*

Treatment of Post-partum Hemorrhage.

DR. JOHN BASSETT writes to the *British Medical Journal* that his rule is to submit patients who are liable to flood to a course of treatment extending over one or two months preparatory to delivery; to give iron in combination with an alkali where the patient is thin and unable to digest much fatty food, and with an acid when the patient is stout or the body covered with fat. Before the introduction of the treatment by Dr. Barnes of the perchloride injection we had to rely upon pressure, cold and ergot. Dr. Bassett found on many occasions that pressure of the abdominal aorta by the forefinger of the right hand was the easiest and quickest method of checking the hemorrhage; and that pressure and friction of the uterus threw it into a state of spasm, which expelled the clots, and permitted the flooding to go on unchecked. In such cases ergot and opium were given in combination or alternately with the greatest success. In other cases cold seemed to effect the desired uniform and regular contraction of the uterus. . . . As regards the general question of post-partum hemorrhage it may be described broadly and briefly as arising from two causes. First, certain circumstances which occur during the process of parturition give rise to it; secondly, certain conditions existing in the mother's system are known to cause it, arising from malnutrition or the retention of effete products, producing an alteration in the chemical and physical properties of the blood, a defective or deranged action of the nervous system, and a want of tone and power in the muscular fibres of the uterus. The first of these causes is to be combatted by attention to the details of delivery, and the second by putting the patient in a healthy state before

parturition by preparatory treatment.—
Louisville Medical News.

Cyst of the Broad Ligament Complicating Labor.

Prof. WEBBER (*Detroit Clinic*) reports the following interesting case :

Mrs. P. was confined in June, 1880. The progress of the labor was interrupted by what the physician in attendance first mistook to be a mass of fecal matter in the rectum. After several unsuccessful attempts to remove it by injections, by a more careful examination per rectum and vagina he discovered a tumor.

"This tumor was being rapidly forced down before the foetal head (*i. e.*), it was being forced down between head and sacrum, until it took up a position before the foetal head. After making frequent examinations, during which time more and more of it became tactable, I concluded that the only way delivery could be accomplished was by using instruments. I applied them without the use of anæsthetics, and could not deliver." He then sent for counsel, but before its arrival the funis came down, and could not be replaced, resulting in the death of the child. On the arrival of the consulting physicians the forceps were again applied without avail. At this time the tumor, as described by the doctor, "was about as large as a man's hand, and about twice as thick, pressed flat." They then performed craniotomy and delivered.

Mrs. P. suffered much afterwards from cystitis and inflammation of the soft parts, so much so that at one time her life was despaired of. After a tedious sickness, she finally recovered from the effects of her confinement, when she was examined by two other physicians, and they decided she had an ovarian tumor. In June, 1881, she en-

tered St. Mary's Hospital, and upon examination I found a medium sized tumor in the pelvis pressing well down into the posterior *cul de sac*. At the same time I discovered what she had feared that she was at least four months advanced in pregnancy. From the soft fluctuating character of the tumor and other conditions observable in bi-manual examinations, I doubted the correctness of the diagnosis of her former physicians. I put the patient under the influence of ether and with a large sized aspirator needle punctured the tumor, giving exit to six ounces of the clear limpid fluid peculiar to cysts of the broad ligament. Besides this several ounces were lost by drainage after the needle was withdrawn. By careful examination no evidence of this or any other tumor was discoverable after the needle was removed.

There were no untoward symptoms following this slight operation except perhaps a little irritability of the uterus which was quieted with opiates, and in a short time she left the hospital for home. She returned to Detroit in November, and on the 27th of that month she was taken in labor. On my arrival at her house, I found the os uteri fully dilated with the child in the natural position. I immediately ruptured the membranes and within fifteen minutes thereafter she was delivered of a fine large healthy boy. After the birth of the child I made careful examination of the pelvic organs and I could discover nothing like a tumor. There is no doubt but what the cyst was the cause of all her trouble in her first confinement, and had it been punctured at that time craniotomy would not have been necessary, and the severe cystitis and inflammation of the soft parts would not have occurred.

Retained Placenta.

Dr. H. FROST, of Salem, Va., in *Medical Bi-Weekly*, says:

I was summoned several hours after the birth of the child, to deliver the placenta, which I found closely adherent. The cord had been torn from its attachment. Finding it impossible to remove the whole, I took away as much as I could, about half. I gave her at once quinine, grs. v., every three hours, and used vaginal injections of carbolic acid two or three times a day, and intra-uterine injections of the same at my daily visits. Gave also salicylate of soda. Each day I endeavored to remove the mass, but failed. On the fourth day the placenta was expelled, and the patient recovered without further illness.

I have met with four other cases in which the placenta was firmly adherent; three of them, strange to say, in the same family, and two in the same patient. In each case, after my own efforts failed, I had the advice and assistance of other physicians. In one, after long continued effort the placenta was removed, but the woman died of septicæmia. In each of the other three the placenta was expelled spontaneously on the third or fourth day; one patient died, the others recovered with no illness whatever.

These cases, it seems to me, show that where the placenta is so closely adherent that it cannot be delivered without the desperate efforts which are often made, it is better to leave it for nature to expel, guarding the patient by appropriate remedies against the dangers of septicæmia.

I have been led to report the above cases from hearing an old physician say recently that no patient of his should die with (a retained) placenta; he would prefer that she should lose her life in his efforts to deliver it. It is no doubt a most

distressing alternative we are called on to take; and we feel that if we leave a patient with her labor thus incomplete, we may subject ourselves to reproach, but my experience, limited though it be, convinces me that life is often destroyed by the ill-advised force which is used. It is common to hear doctors say that they never saw a placenta so adherent that they could not remove it. They are more fortunate or more skillful than I, for in each of the cases mentioned above in which the placenta was left in the womb, I found it impossible to feel the placental margin—to determine where it ended, and the uterine surface began. In such a case, what is to be gained by tearing it away piecemeal? Are we not sure to leave some portions still adhering? And would not the retention of a small portion be as dangerous as the retention of the whole mass? Would it not be *more* dangerous? For the whole placenta by its presence provokes the womb to constant expulsive efforts, while the small portion, being better tolerated, would probably be retained longer and thus expose the patient for a longer time to the danger of blood-poisoning.

I hope I will not be understood as advocating inaction in this serious complication of labor. By no means. Let us use every reasonable effort to remove the placenta, but let us be careful not to push those efforts too far. Many lives have no doubt been sacrificed from a conviction on the part of the attendant that the placenta must be extracted *at all hazards*. May the report of these cases induce some to let their patients alone before they inflict injury on them. —*Southern Medical Record*.

[The *expectant* plan of treating a stubbornly adherent placenta has the endorsement of good authorities. Inseparable adhesions like the above, must, however, be extremely rare.]—J

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Prolapse of the Ovary: its Differential Diagnosis:

O. E. HERRICK, M. D., Grand Rapids, Michigan: While the above lesion is comparatively rare, even in gynecological practice, it is still important that we be able to differentiate between it and numerous other abnormal conditions often found within the female pelvic cavity. There are a number of conditions quite similar to, and very liable to be mistaken for, prolapse of the ovary; and, indeed, some of them may be associated with that difficulty, in which case the diagnosis is rendered still more obscure. Among the abnormalities most likely to be mistaken for ovarian prolapse may be mentioned uterine retroversion and retroflexion, cyst of the broad ligaments, uterine fibroids attached to the posterior wall, especially the pedunculated variety, fibrous tumors and cysto-fibroma of the ovary. Dermoid, and, in fact, any and all of the tumors found in that locality, may, when small, be mistaken for, and confounded with, prolapse of the ovary. The inflammatory deposit from an old cellulitis, scybala in the rectum and cancerous deposits have in their turn been mistaken for the ovary in Douglas' cul-de-sac. From the frequency of reported cases of ovarian prolapse and their comparative rarity in female hospitals and in the practice of our most noted gynecologists, together with the limited space devoted to the attention of the subject in all text-books upon diseases of women, I am led to think that perhaps some of the many cases

reported as such may be mistaken for, or at least complicated with, some of the conditions enumerated above. The differential diagnosis is rendered comparatively easy, if a few of the following points are borne in mind.

In prolapse of the ovary, we have a small tumor in Douglas' cul-de-sac, extremely tender and painful upon the least pressure, and varying from the size of a small walnut to that of a hen's egg, and about that shape, being always enlarged sufficiently to make it prolapse. It is situated and confined to one side of the median line in the cul-de-sac, and can be replaced only in the direction from which it is prolapsed. The reason for this is readily seen, when we remember that it is attached by its anterior margin to the broad ligament, and can only become prolapsed by either dragging that ligament down or by stretching it, and hence displacement only occurs when from some cause the ovary becomes enlarged and sufficiently heavy to prolapse from its own weight, or is dragged down by some growth attached to it. Unless it is held down by some growth, or is adhered through inflammation to the surrounding parts, it is easily reduced by putting the woman in the knee-chest position, when it will usually fall back in place by its own weight; if it does not, it is easily pushed back by the finger or sound in the vagina or finger in the rectum, and can be held there by packing the cul-de-sac with cotton or oakum, and then holding it there by a properly fitting pessary or support. The pessary is necessary for the reason that there is usually in such cases more or less displacement of the

uterus; as a rule there is retroversion to a greater or less degree. I have given the above description in detail, for the reason that the subject is but barely mentioned in any of the text-books upon gynecology with which I am familiar.

Prolapse of the ovary may be known from retroversion or retroflexion by the absence of that excessive tenderness upon pressure, though there may be and often is moderate tenderness in both retroversion and retroflexion; again, the prolapsed ovary is confined to one side of the median line, while in the other two conditions the opposite is true. As there is generally retroversion accompanying prolapse of the ovary, it is important to distinguish the difference between a retroversion with and one without. Without prolapse of the ovary there is a tumor occupying Douglas' cul-de-sac, larger than the ovary and presenting the round feel of the fundus of the uterus, and not the oval feel of the ovary; it is only moderately tender to touch, as a rule, in contradistinction to the excessive tenderness of the ovary. Again, in most cases of either retroversion or retroflexion, the cervix points more to the anterior than to the posterior wall of the vagina, though it is not so pronounced in retroflexion. The introduction of the uterine sound will also detect either of these conditions; and, lastly, the introduction of the finger in the rectum will always determine the character of the tumor in the cul-de-sac, as it can be thus felt in its entirety.

From cyst of the broad ligament, or other cystic tumors, prolapse of ovary may be known from the fact that these tumors do not prolapse into the cul-de-sac as completely as does an enlarged ovary; besides, these growths are fluctuating in character, instead of hard like the ovary; they are different in shape

and not tender. It is scarcely possible to mistake a dermoid growth for the ovary, as they are unlike in shape, and a dermoid could be only partially displaced into the cul-de-sac. Inflammatory deposits can be easily distinguished by their board-like feel and irregular outline, usually filling the greater portion of the cul-de-sac.

Fibroids, and especially the pedunculated variety, are the most likely to be mistaken for a prolapsed ovary, for many times they are nearly the shape and size of the ovary; but, with the exercise of a little care and attention to a few distinctive features, the error may be avoided. A fibroid is not sensitive to the touch; it is much more dense than the ovary, often occupies the median line, and is as liable to move in any other direction as that of the broad ligament. In the pedunculated variety, if the pedicle is long enough to admit of motion, the growth may be found upon one side one day and the other the next; may be in the median line or not; this is never true of a prolapsed ovary. When there is a fibroid growth or cysto-fibroma attached to the broad ligament and complicated with prolapse of the ovary, I can see how any one might be misled in making a diagnosis, and it is important that great care be exercised in examining such cases before a positive diagnosis is given.

[The rules given above for the diagnosis of prolapsus of the ovaries are not all reliable. Tenderness is often absent, and in marked cases the ovary extends downward and inward to the centre of the sac of Douglas.]—A. J. C. S.

Laceration of the Perineum and Sphincter Ani Complicated by a Recto-Vaginal Fistula.

Dr. J. E. ROUSE (*Canada Lancet*): On the 15th of November I received a note

from Dr. Hanna, of Lansdown, asking me if I would operate on a lady for restoration of a completely ruptured perineum. He stated that she had been confined only six weeks previous of her second child, and that the accident occurred under the care of another physician, nearly three years before, in her first labor. Without obtaining any more particulars I agreed with her friends to operate, and went to see her on the 26th of November, prepared to do so if there was a reasonable prospect of success, and the woman properly prepared. But when I came to examine the state of the parts and saw the extent of the lesion, I regretted my promise, and were it not for the anxiety of the woman to obtain relief, twice the fee agreed on would not have induced me to touch the case, as I deemed success very problematical. The history is briefly this: June 22d, 1878, pains began at 6 A.M. very light until 1 P.M. when they became more regular and strong. Membranes ruptured at 2 P.M., from that time until 7 the pains were quite strong. Between 7 and 8 they were feeble with long intervals. The physician in attendance applied the forceps and the child was born in a few minutes. The next day the doctor put in three sutures, leaving them in fifteen days, at the end of which time no union had occurred. Ever since then she has had no control of the bowel, both flatus and fæces passing in spite of her every effort. The fæces also pass into the vagina, obliging her to wash out the part frequently. Although only 23 years old her life has become a very burden, and rather than continue an object of disgust to herself, she is willing to submit to any operation that will afford the slightest prospect of relief.

Placing her on a table in good position before the window, I saw a widely gaping cavity into which could be put

an ordinary-sized goose egg, without stretching the parts in the least. The perineum was entirely wiped out of existence, the sphincter ani torn through and lying at the lower or posterior margin of the anus (which was open) with its inner fibres contracted and the ends marked by a distinct pit on either side. A band of skin and mucous membrane one-eighth of an inch in diameter had united in front of the anus, thus converting what had originally been a rent into a recto-vaginal fistula of over an inch in extent. On passing my left index finger into the rectum and lifting up the posterior vaginal wall, a cicatrix, at the junction of the left lateral with the posterior wall, fully three inches long and extending nearly into the cul-de-sac, was discovered. The original rent had been through both the vaginal and rectal tissues, and in uniting had bound the parts so tightly down that it was almost impossible to raise them sufficiently to get a good view. In order to have the patient in as good a condition as practicable I deferred the operation for ten days, in the mean time ordering such diet as would, in the process of digestion, leave the least debris, and giving instruction to have her bowels freely opened by cathartic pills each day until the ninth, when an opiate was to be given so as to lock them up.

On the 6th of December, hearing that the patient was ready, I went up and operated. I first washed out the rectum with carbolyzed warm water, but the opiate not having had the desired effect, nearly an hour was consumed before the water returned clear. First marking the points on the posterior wall of the vagina and on either labium to which the denudation was to extend, the operation was begun by picking up the skin with a tenaculum at the left extremity of the sphincter, on a line with the posterior

margin of the anus, and freshening the end of the muscle with the scissors. Then a narrow strip of mucous membrane was denuded completely around the fistula (which was converted into a rent by dividing the narrow band at its lower margin) and down the right side to the other extremity of the muscle. In this manner strip after strip of mucous membrane was removed from the side and posterior walls of the vagina, the greatest difficulty being experienced in getting at the parts bound down by the cicatrix, and it was only by exercising patience that it could be accomplished. To add to the trouble the bowels, notwithstanding the opiate, kept moving every eight or ten minutes during the whole time, occasioning a great deal of delay in cleansing. Having reached the points marking the limit of denudation, the first suture was put in by entering an ordinary two-inch needle, threaded with silk to which a silver wire was attached, below the sphincter close to the left side of the anus, and carrying it up in the cellular tissue to a point one-fourth of an inch above the limit of the rent, then around it and down the right side to a point exactly opposite that of entrance. The second suture was entered on the same plane, catching the end of the muscle and following a course parallel to the first and one-half inch higher up. The third passed directly across the upper margin of the anus and under the first two so as the more effectually to bind the muscle in its place when brought into position. The fourth, fifth and sixth sutures were entered about half an inch from the edge of the left labium, passed back through the tissue of the lateral wall, then through the tissue of the posterior wall in front of the rectum and out through the right wall to a point opposite that of entrance. The sutures were about half an inch apart.

By taking an end of wire No. 1 in either hand and pulling, at the same time pushing up the sphincter with the index fingers, the muscle was made to encircle the anus, and was secured by a couple of twists of the wire. Suture No. 2 brought the outer fibres of the severed muscle in contact. No. 3 was put in at the suggestion of Dr. Emmet, to whom I had shown a rough sketch of the parts when in New York the previous week, and I have no doubt that it added materially to the success of the operation by effectually keeping the muscle in position. Nos. 4, 5 and 6 brought the sides and posterior wall in contact,



thus completely restoring the perineum. In twisting the sutures care was taken to do no more than bring the parts in contact so as to lessen the danger of cutting through or producing strangulation when swelling occurred. The sutures were left three inches long and secured together by a piece of rubber tubing over the ends and wrapped with wire. All blood stains were now washed away, the thighs tied together, a soft pad being placed between the knees, and the patient put to bed. The operation lasted one hour and thirty minutes, but, had it not been for the trouble

given by the old cicatrix and the continued action of the bowels, it would have been done in less than half the time. An opiate was given to confine the bowels, and instructions left for a daily dose until the sixth day, when an enema of warm oil was to be administered, Dr. Hanna in the meantime attending to the bladder and washing out the vagina. The same diet was continued as before the operation. The bowels, unmanageable all through, operated on the night of the fifth day, before Dr. Hanna gave the enema, and caused great pain, but did no further harm. December 14th I removed the sutures and found the parts united. She was kept in bed with her thighs tied for ten days longer, when she was allowed to get up. Dr. Hanna reported subsequently that the operation was a complete success.

Thus has a life been changed from a state of great misery to one of enjoyment by an operation which, at the outset, seemed almost hopeless.

Bennet on Laceration of the Cervix Uteri.

In the Gynecological Section of the International Medical Congress of London, Dr. J. Henry Bennet read a paper calculated to check some of the enthusiasm with which the advocates of Emmet's operation have proclaimed the virtues of this method for relieving uterine disease. Referring to the work of American and German gynecologists during the past few years, he credits them, the former especially, with doing good work in bringing the matter of laceration so prominently before the profession, but he dissents from the view that such lacerations are the fertile causes of hypertrophy, displacement, leucorrhœa, sterility, or are apt to produce *post-partum* hemorrhage, septicæmia, metritis, and the like.

He admits that these morbid conditions may follow labor in a healthy female from manual or instrumental interference, but he regards such accidents as exceptional. In an experience of forty years he has always succeeded in healing the laceration and in curing the morbid manifestations accompanying them, by simple surgical means and appliances, without any plastic operation. In a certain class of cases the propriety of such an operation may be decisive, as when the laceration extends to the bladder. He observes also that, singularly enough, during the last twenty years, gynecologists, eminent on both sides of the water, advocated deep incision of the cervix, even down to the body of the uterus, for nearly every uterine ailment—in fact, the same class that now are to be cured by the opposite course of treatment, viz.: sewing up the rents. Such extreme doctrines, therefore, rebut themselves. The explanation given of the apparently marvellous cases is as follows: those who perform the operations do not themselves, in most instances, follow up their subsequent histories.

The eminent gynecologist leaves the operation to the family attendant, thinking most conscientiously, that he has cured the case, when, in reality, the health has been little, if at all, improved; or the patient may belong to that class of women whose uterus and ovaries require attention from the date of menstruation to the menopause. No treatment of any form or kind will give them complete relief, but they are always ready and willing to submit to anything new in the way of treatment or practice, and, whatever is done, are apt to think themselves improved. The real therapeutic value of any treatment in such cases cannot be appreciated until years have passed by. Dr. Bennet states that, in uttering

this protest against methods that he regards as unreasonably surgical, he has no desire to obstruct real progress, but will accept new views and new doctrines, provided they have a legitimate basis on facts.—*British Medical Journal*.—*Med. Record*.

[If Dr. Bennet could see the treatment of the laceration of the cervix uteri as practised in this country he would be led to more correct conclusions than those evolved by his theories and reasoning from false premises.]

A. J. C. S.

The Blood in Chlorosis and Pregnancy.

From the examination of the blood in twenty-two cases of pregnancy and in seven of chlorosis, made with Hayem's chronometer, Dr. FREDERICK WILLCOCKS draws the following conclusions:

1. That a more or less considerable diminution of hæmoglobin is found in both pregnancy and chlorosis, especially in the latter, but that beyond this fact no obvious analogy exists between them.

2. That in pregnancy the diminution of color is due to a fall in the number of red cells, and that the individual cell remains of high value. In chlorosis both the cells and the individual value are reduced, the latter being in excess of the former.

3. That the blood-state of healthy pregnancy is due to a larger relative increase in the water of the plasma, and that this condition does not constitute a true anæmia, but is due to the progressive enlargement of the vascular area during pregnancy.—*Lancet*.

The Treatment of Chlorosis.

Dr. ZANDER (*Le Progrès Médical*) is opposed to the theory which accounts for chlorosis upon the hypothesis that

the food is deficient in iron. He rather supposes that the fault lies not in an insufficient quantity of iron in the food, but in insufficient absorption of such iron as is present, owing to morbid changes in the secretions of the digestive tract, more especially owing to the absence of a proper proportion of hydrochloric acid in the gastric juice. As a result of this the proteid foods are incompletely digested and nutrition is affected. In the treatment of chlorosis the author therefore prescribes two to four grams of hydrochloric acid diluted with 200 grams of water; a tablespoon or two to be taken after each meal. In very obstinate cases pepsin may be mixed with the acid, and the results thus obtained are said to be most satisfactory.—*The Practitioner*.

[This treatment is no doubt beneficial because it aids digestion. Dr. Zander's theory is like the one which he condemns, doubtful.]—A. J. C. S.

In Chlorosis.

R. Ferri sulph. granulata. ext. gentianæ, āā grs. xxx. M. Divide into 12 pills, and order one to be taken three times a day.—*Med. Gazette*.

Membranous Dysmenorrhœa.

R. Chloral hydrate; potass, brom., āā. 3 ii.; morphinæ sulph., gr. iss.; syrupi aurantii corticis, ʒ iii. M. Sig.—A deserts- spoonful in a wineglassful of water every four hours while in pain.—*Dr. T. G. Thomas*.—*Ibid*.

[This is undoubtedly very useful when freshly prepared, but our experience has been that the chloral hydrate in such a mixture becomes inert after twenty-four or at most, forty-eight hours.]—ED.

The Electrical Treatment of Dysmenorrhœa.Dr. J. D. MANN (*Lancet*.)

The now old-fashioned term "neuralgic dysmenorrhœa" still expresses all that is known of the causation of many cases of this disorder. All that can be diagnosed in an otherwise healthy uterus is an irritable condition of the mucous membrane of the cavity, which, under certain circumstances, evokes painful, clonic contractions of the organ. In such cases, when the sound reaches the uterine cavity, the patient experiences pain identical with that of dysmenorrhœa, the contact of the instrument with the neurotic membrane being sufficient to set up irregular uterine action. In this form of the disease much relief is afforded by electricity, the result, probably, of altered nutrition, and of the direct action of the current on the terminal nerves. Associated more or less with dysmenorrhœa is ovarian irritation or neuralgia. When not dependent upon uterine disease this disorder may be successfully treated by electricity, on the principles already laid down. It is often sufficient to administer a current of eighty-five or ninety dix-millivebers, by means of external electrodes, the anode being placed over the affected ovary or ovaries, and the cathode over the lumbar spine. If the accompanying dysmenorrhœa is urgent, it is preferable to introduce the anode into the uterus, and apply the cathode over the ovarian region. If there is suspicion of ovaritis, electricity is not admissible; but tenderness with slight enlargement of the organ (recognizable on bi-manual examination), with absence of systemic disturbance, is probably due to passive hyperæmia, and is often greatly relieved by the constant current. The relief afforded in simple ovarian irritation is frequently very striking, a soothing ef-

fect being experienced by the patient almost as soon as the circuit is closed. In many cases the result of the treatment will be rendered more permanent by the administration of the following nervine tonic: Valerianate of zinc, valerianate of quinine, valerianate of iron, of each one grain, made into pill; one to be taken twice a day. The pills should be protected by an impervious coating, as the combinations of valerianic acid have an exceedingly disagreeable odor.

Some forms of sub-involution of the uterus are amenable to the action of electricity. Retarded involution cannot be regarded as a disease *per se*, but rather as the result of one or more morbid conditions. Retention of fragments of placenta or membranes, inflammation of the cervix from laceration or bruising during labor, and partial prolapse, are among the most common causes. It is obvious that sub-involution thus produced can only be cured by the removal of the exciting cause, and this is to be accomplished by means other than electricity. Simple sub-involution dependent upon muscular atony, or upon malnutrition, alone comes within the range of electro-therapeutics. For the treatment to be successful it is essential that the disease should be attacked in the early stage. It is well known that prolonged hyperæmia produces hyperplasia of the areolar tissue in the organ or part affected. When once this stage of sclerosis is reached in the uterus, and an excess of fibrous tissue obtains over the muscular elements, absorption becomes a matter of grave difficulty, if not an impossibility. In dealing with a hypertrophied uterus composed of a mass of muscular fibres infiltrated with fluid, and but sparingly so with cellular growth, any method of treatment which will stimulate the nutrition of the organ and

accelerate the absorption of the morbid products tends to promote a cure. Such a stimulant is electricity. Unless contra indicated an insulated sound forming the cathode is introduced into the uterus, the anode is placed over the lumbar spine, and a current of about ninety dix-millivebers is passed for ten or twelve minutes, every alternate or third day. During the first half of each application the current should be stable; during the latter half it may be interrupted at intervals, in order to stimulate the contractile properties of the womb. While the interruptions are being made it is desirable to reduce the current strength, as the opening and closing of the circuit are attended by slight shocks, which are very disagreeable, if too strong. The patient should maintain the horizontal posture for some hours after each application. If the uterine wall is so soft as to render the passage of a sound dangerous, a cervical electrode may be used in place of the sound. In a case of sub-involution which I recently treated with electricity, each application was followed by a temporary discharge, and slight pain, of the after-pain type; the uterus was reduced to its normal condition in seven weeks. I need hardly observe that perimetritic inflammation, or any latent pelvic disease, is contra-indicated of the internal use of electricity.—*Med. and Surg. Reporter.*

In Dysmenorrhœa and Ovarian Irritation with Reflex Disturbance.

R. Coniæ, grs. 8; gelatini, grs 160; glycerini, 3. 2.

M. Divide into eight pessaries. One to be introduced into the vagina every night.—*Med. Gazette.*

Supposed Ovarian Neuralgia.

Dr. J. W. McAFEE reports the following case in the *Pacific Medical and Sur-*

gical Journal, which he considers an inexcusable mistake in diagnosis, and showing the fallacy of treating symptoms. A young lady, aged twenty-two, had suffered for six years from neuralgia of the right ovary. For the first three years the attacks were slight and irregular, gradually increasing both in duration and severity. She had received all kinds of treatment for three years without avail. She finally became quite melancholy. General health and menstruation regular. External examination revealed neither tenderness nor enlargement in the ovarian region. Examination per vaginam showed uterus enlarged, but not painful on probing. Anterior lip of cervix large, dark and congested; posterior completely denuded of its epithelial coat, and covered with large fungoid granulation, which had a tendency to bleed on the slightest provocation. From this granular surface was poured out a thick, tenacious discharge, streaked with blood and pus. After thorough cleansing, iodine was applied, and the parts dressed with absorbent cotton and bismuth cream. Ordered a douche of one gallon of hot water to be used night and morning and discontinued all drugs. The next day the anterior lip of the os was much swollen, dark and tense; with a sharp bistoury he made several punctures, which bled freely and gave much relief. This treatment was continued for ten days without much change. It was now determined to use nitrate of silver. The stick was applied freely to the denuded surface, as well as the cervical canal. It acted like a charm; the improvement was rapid and steady. After a few days the ovarian pain had almost entirely disappeared. After eight weeks of treatment the uterus was reduced to its normal size, discharge disappeared, and the cervix was reduced to a healthy con-

dition. The ovarian neuralgia was completely cured.—*Med. and Surg. Reporter.*

Removal of a Cyst of the Pancreas

Dr. N. BOZEMAN presented a specimen accompanied by the following history: The patient was the wife of a prominent physician of Texas, forty-one years of age, tall and robust, weighing nearly two hundred pounds, and perfectly healthy up to seven years ago, except occasional attacks of dyspepsia. Seven years ago she had, for the first time, pain in the right iliac region, extending down the right thigh and occasionally attended with numbness. Five years ago the abdomen began to enlarge, slowly at first, but gradually increased in size upon the left side, with a corresponding flatness upon the right side. The point at which the enlargement was first noticed was higher than would naturally be expected for an ovarian cyst. At that time no special importance was attached to the enlargement of the abdomen, either by herself or husband. It progressed in the ordinary way up to six or seven months ago, when it suddenly began to grow rapidly, and finally the entire abdomen was distended symmetrically. At the same time the patient began to lose flesh. The case was diagnosticated as one of ovarian cyst by Professor Richardson, of New Orleans, who advised the patient to consult Dr. Bozeman. On November 19, 1881, the patient having entered the Woman's Hospital, Dr. Bozeman examined her and diagnosticated ovarian cyst. She was also examined by his colleagues, Drs. Thomas and Emmet, both of whom confirmed his diagnosis. An operation was decided upon, and it was performed on the second day of December, under Listerism. Nothing unusual presented itself in the early stage of the operation. When the tumor

was reached, through an incision below the umbilicus, its appearance was nearly that presented by an ordinary unilocular ovarian cyst, except, perhaps, it had a little deeper pearlsh color. It was tapped, and two and one-half gallons of fluid were removed. After the greater part of the fluid was drawn off, about two-thirds of the cyst was drawn through the abdominal opening, and then, for the first time, Dr. Bozeman suspected that it was not ovarian. He then passed his hand into the peritoneal cavity and found the uterus and both ovaries, and also determined that the cyst had an origin somewhere in the upper part of the abdomen. The abdominal incision was extended upwards two inches above the umbilicus. The stomach was then found crowded against the diaphragm, and the bowels were deep in the abdominal cavity below the cyst. The cyst had an extensive attachment, apparently to the transverse mesocolon. After some manipulation he finally reached the pancreas, where he discovered a large vein, subsequently determined to be the splenic, which was very tortuous, and offered considerable obstruction to the operation, owing to its close relationship to the pedicle. Finally he traced the cyst down until he reached the tail of the pancreas, which was turned up on the side of the cyst, and firmly adherent to it to the extent of two inches. He then proceeded to separate the extremity of the pancreas from the cyst by dissection, and, when completely separated, the pancreas spread out and presented its natural appearance.

The attachment of the cyst was at the junction of the outer with the inner two-thirds of the organ, and it had a pedicle three-fourths of an inch in length, and about three-fourths of an inch in diameter. The veins of the

pedicle were very large. Having fairly reached the pedicle, he transfixed it with a needle, ligated it in the usual way, and cut it off. The result was that he cut out the bottom of the cyst, as shown in the specimen. The portion of the cyst, however, which remained attached to the pedicle was subsequently completely removed by dissection. The artery which supplied the growth was doubtless a branch of the splenic, and it had attained a very large size—as large as the brachial. The loss of blood was small, and not a single bleeding vessel required a ligature. The fluid which the cyst contained was of a light brownish color, its specific gravity was 1020, and it had an acid reaction, in that respect differing from the fluid removed from the ordinary ovarian cyst, which is alkaline. The girth of the patient before the operation was forty-one inches, and both oblique measurements, from the anterior superior spinous processes of the ilia to the umbilicus, were the same—nine inches. The tumor, with the fluid, weighed twenty and one-half pounds.

The specimen was also interesting in another respect, namely: with reference to the point of attachment, which was almost precisely in the position occupied by the bullet in the late case of our deceased President. The patient underwent special preparation for the operation. She took salicin, fifteen grains three times a day for two weeks. On the morning of the day on which the operation was performed, she received fifteen grains of quinine with one of opium, and when she went upon the table she was thoroughly cinchonized. The patient rallied from the anesthetic and from the operation without any shock whatever. After the operation she took by the rectum, at intervals of six hours, ten grains of quinine with two

ounces of beef-juice, half a drachm of liquor opii comp., and two drachms of brandy. On the third day the temperature reached its highest point, 101.5°F., but the pulse never rose above 98. Subsequently the pulse fell to 80, and the quantity of quinine was gradually lessened, but on the eighth day after stopping the quinine the temperature rose to 102.8°F. The quinine was again resumed, ten grains every six hours, and the temperature, in the course of thirty-six hours, fell to 99.5°F., and subsequently the patient had progressed in the most satisfactory manner, and was discharged cured Jan. 9, 1882, the thirty-eighth day after the operation.—*Med. Record.*

DISEASES OF CHILDREN.

Infant Feeding.

Dr. ELLIOTT, of the Bristol Hospital for Sick Children (*The Practitioner*).

After the age of six months the chief difficulty arises, and the following foods are suggested. 1. Boil the crumb of bread for two hours in water, taking care it does not burn; then add a lump of sugar, a pinch of salt, and pour a little new milk upon it while boiling hot. 2. Cut thin slices of bread into a basin, cover the bread with cold water, place in an oven to bake; when sufficiently baked take it out, beat the bread up with the fork, slightly sweeten and pour on milk. 3. Baked flour. Bake some biscuit flour in a slow oven until it is of a light fawn color; reduce it with a rolling pin to a fine powder, and keep it in a tin ready for use. Two tablespoonfuls to half a pint of milk boiled and sweetened. 4. Boil a teaspoonful of powdered barley (ground in a coffee mill) with a little salt in half a pint of water for fifteen minutes; strain, mix with

half as much boiled milk, and add a lump of sugar. 5. Scotch oatmeal. Prepare in the same way as 4. This food is especially useful for regulating the bowels when they have a tendency to become constipated. 6. Robb's biscuits. 7. Ridge's or Neaves' farinaceous food for infants. 8. Revalenta Arabica, or lentil food. 9. Cadbury's cocoa essence, Fry's cocoa powder, or cocoa nibs. Dissolve a teaspoonful of either of the two first in half a pint of boiling milk and water (equal parts): of the nibbs take one ounce and boil it in a pint and a half of water for five hours, strain and add new milk and sugar. Cocoa makes an excellent food for thin and wasted infants, who take it greedily and soon improve in health.

These foods are to be given lukewarm through a nursing bottle. In hot weather test the food with a small strip of litmus paper. If the paper turns red, make a fresh mess, or add a small pinch of baking soda to the food.—*Can. Jour. of Med. Sciences.*

The Treatment of Scarlatina.

In an article published in *Le Concours Médical*, Dr. Paul Gerne makes the following suggestions for the treatment of scarlatina. He says:

We shall not here attempt to decide on the prophylactic and curative merits of belladonna; we will only say that experiments made for that purpose have given widely divergent results. If it is desired to use this remedy, the following is a good formula:

℞. Ext. belladonna, 0.15 c.=gr.ii¼; distilled water, 30 gm.=3 viiss; alcohol, rectified, 1 gm.=℥xv. M.

Of this mixture, give as many drops, morning and evening, as there are years in the patient's age.

In regular and normal forms of the disease the treatment should be purely

hygienic; the patient must be kept in bed, in a room having a temperature of from 64° to 68°, F.

The patient should not be surfeited with warm drinks; he may have reasonable quantities of lemonade, to which wine can be added, when there are symptoms of weakness.

Until the period of desquamation is reached, the food should consist of broth, unless otherwise specially indicated.

The infectious nature of the disease warrants the use, as recommended by Scott, of an aqueous solution of sulphophenate of soda, in doses of from 0.30 centigr. to 1 gram (=grs. ivss—xv.) In irregular forms, the predominating symptoms will, of course, indicate the particular measures that should be adopted. The hyperthermia in those ataxic forms rapidly accompanied by serious nervous, comatose, convulsive, or dyspnoëic symptoms, is successfully checked by cold lotions and affusions, and in very severe cases, cold baths may even be given.

As an anti-thermic remedy, we use sulphate of quinine; but salicylate of soda should never be displayed, because it might superinduce nephritis, which is always imminent, or aggravate it, if already present.

In syncopal forms, wine, alcohol, cinchona and digitalis are to be exhibited.

In gastro-intestinal forms (complicated from the start by incoercible vomiting and profuse and persistent diarrhœa), opiates are to be used, also seltzer water, and ice in small pieces be frequently given by the mouth.

We will conclude with a few remarks on the experiments made by Dr. Demme, of Berne, with *pilocarpine*. According to him, in scarlatina, when the exanthema is retarded, excellent results may be derived from the diaphoretic effects

of pilocarpine, and the serious nervous symptoms usually occurring in such cases may be averted. But this medication, even when displayed at the outset of the eruptive period, is powerless in preventing renal complications. By stimulating diaphoresis, it may lessen the gravity of the uræmic symptoms, which frequently happen during the period of decrease. But the use of this remedy requires the greatest caution; its depressive action upon the heart, when given in rather high doses, predisposes to collapse, and this danger is almost constantly impending, after the use, during a few days, of hypodermic injections of one-sixth of a grain of chlorhydrate of pilocarpine. Dr. Demme, therefore, recommends that this remedy should only be administered in limited doses, and that its use be preceded by cordials, generous wines, or strong infusions of coffee or tea.

Headache in Children.

DR. DAY read a paper on this subject before a recent meeting of the Harveian Society of London (*London Lancet*). He alluded to the two great causes of headache, from a pathological point of view, viz: cerebral anæmia and cerebral hyperæmia. He said that habitual headaches in children indicate an irritable and exhausted brain, and if intellectual exertion be carried too far in such cases, mischief is soon likely to ensue. If intellectual exertion be carried beyond a certain point, the brain becomes anæmic, fatigued, and the nutrition in the ganglion cells of the cortex becomes impaired, diseased, or in some way altered from health. The author referred to neuralgia, or one-sided headache, which he said was more common in children than was generally supposed. He had known headache in connection with chorea and dental caries. Dr. Cheadle

considered foul air and gas were the chief causes of study-headache; he referred to headaches in rickety children. This occurred just after the skull closed, was continuous, but gradually subsided. Dr. Mackenzie particularly insisted on the importance of careful examination of the eyes in cases of headache of children. Muscular asthenopia was a cause of headache which sometimes was mistaken for serious organic disease. He mentioned the case of a schoolboy brought to him under this supposition, but myopia was found and corrected, and the headache disappeared. The same thing occasionally occurred with hypermetropia. Next he pointed out that ear disease was sometimes the cause of headache; which is important as significant of commencing meningeal or cerebral inflammation. In all cases, therefore, of headache in children, it is very important to examine the ear and the eye, using the ophthalmoscope, which will be of great value in detecting organic disease. He remarked that pain in the head, a valuable sign of tumor of the brain, was no certain indication of localization of the tumor, unless there was corresponding pain on percussion. The president, in conclusion, said that headache, though not a common symptom in children, was one of import, and frequently indicated advanced disease. —*Med. and Surg. Reporter.*

Intertrigo of Children.

DR. KLAMM (*Le Progrès Médical*, March 11, 1882,) claims that by the use of the following mixture he has had very good results in the treatment of intertrigo in young children. Calcined magnesia, fifty parts, talc powder one hundred parts, salicylic acid two parts, and five parts of any olo-balsamic mixture. The magnesia should be employed in a state of very fine powder. This mix-

ture has been also found of value in treatment of the ecthyma and eczema which develop soon after birth.—*Chic. Med. Review.*

Convulsions and Epileptic Attacks of Children.

Chlorate of Potash.—Young children from the first to the sixth year, particularly those sleeping in overcrowded rooms, are subject to frequent attacks at night of screaming, with insensibility and semi-convulsions and somnambulism if not watched, and something approaching to the *petit mal*, due to the inhalation of air deficient in oxygen and laden with carbonic acid and other morbid products, a persistence in this habit often leading to tubercle of the brain and lungs. For this condition I have always found chlorate of potassium a sovereign remedy, and for the true convulsion and epileptic attacks of children it has proved not only curative, but more important still, a true preventive. For the adult epileptic, although not so useful as the bromide, I have prescribed with great advantage this salt, alone and in combination with the bromide.—Dr. ALEX. HARKIN, *Dub. Med. Jour.*—*South. Practitioner.*

Bromide of Ammonium in Whooping Cough.

A writer out West (*Med. News*), who has had considerable experience in the treatment of this affection recommends bromide of ammonium, in doses of from one to four grains three or four times daily, according to the age of the child. He was led to use it from having seen it highly recommended by Dr. Kormann, and was much impressed with its influence over the disease. It is best administered in syrup, or in the form of an elixir. *Can. Lancet.*

Benzole Inhalations in Whooping Cough.

According to an anonymous writer in the London *Lancet*, benzole will check

the spasm and relieve the whoop in this disease, using a spray apparatus.—*Det. Clinic.*

Simon on Large Doses of Belladonna in Whooping Cough.

In the *Hôpital des Enfants Malades*, of Paris, M. SIMON (*Gazette des Hôpitaux*) makes frequent use of belladonna in various forms; less often of the neutral sulphate of atropia. He cites a case of whooping cough in a child of three and one-half years, where he gave during the first day the unusually large dose of thirty drops of the tincture of belladonna; on the next day, forty drops; and on the following, sixty drops, continuing this latter amount for ten days, during which time the medicine was borne very well, and the attack greatly moderated. The same good fortune attended him in prescribing a similar amount for a second child, four years old. In a third instance, a child three and one-half years old received between forty and fifty drops per day. In a young girl of thirteen the dosage was at first ten, and finally twenty drops, the amount being less well borne by the older children. Under the age of two he very rarely uses belladonna, but if he were called upon to prescribe it for an infant one year old, the dose would be from one to five drops. Belladonna is much preferred to atropia.—*Medical Record.*

OBSTETRICS.

Abdominal Pregnancy.

Dr. LEOPOLD, of Leipsic, (*Archiv. f. Gynaek*), reports a series of experiments in abdominal pregnancy, artificially produced. He opened the abdomen and uterus of a pregnant rabbit and the abdomen of another not pregnant. He then transferred in some cases the embryo, in

others the entire ovum, from the pregnant animal to the abdominal cavity of the other. The wound was then closed.

The experiments covered various stages of gestation. The following results were noted: In one class of cases peritonitis and death followed; in the other the foreign body became encapsulated. In the cases in which peritonitis occurred the fœtus rapidly disintegrated.

In case of the very smallest embryos the disintegration was so rapid that no trace of the transplanted embryo could be found in the animals, which died on the second day. Of the older embryos, only the softer parts were absorbed.

The animals belonging to the other class of cases, in which no peritonitis occurred, were killed at periods of from three to seventy days after operation. In these cases the ovum was encapsulated. The smaller embryos had undergone total or partial absorption. The older ones had suffered more or less complete absorption of the soft structures, while the skeleton remained and showed evidence of growth of bone and cartilage.

Dr. Leopold infers from the results of his experiments that extra-uterine pregnancy may terminate in rupture of the fruit-sac, and encapsulation of the products of conception much oftener than has been supposed. Such a case would present merely the symptoms of pelvic hæmatocele.

Prevention of Septicæmia in Childbed.

Dr. ROBERT BARNES gives the following rules:

1. Keep the door shut against the enemy by maintaining contraction of the uterus.
2. Prevent the enemy from forming and collecting, by irrigating the parturient canal with antiseptic fluids.
3. Eject the enemy as fast as he ef-

fects an entry—that is, keep the excretory organs in activity.

4. Guard the lying-in chamber against the approach of foreign poisons.

5. Fortify the patient against the attack of the enemy by keeping up due supplies of wholesome food.

Among the measures recommended by Dr. Barnes in pursuance of these rules are the use of an aperient the day following labor, and the administration, three times daily for three weeks, of a mixture containing quinine, ergot, and digitalis.

Intra-Arterial Injection of Chloride of Sodium in Post-Partum Hemorrhage.

BISCHOFF (*Centrablatt f. Gynaek.*, Nov. 12, '81) takes occasion to show that even in presence of the gravest dangers from hemorrhage an intra-arterial injection of an alkaline solution of chloride of sodium, as demonstrated by Schwarr upon animals, may safely be employed in the human subject. He reports the case of a woman in whom, in his opinion, death was imminent from post-partum hemorrhage. He injected into the radial artery 1250 c.c. of a six per cent. solution of sodic chloride containing a few drops of liquor potassæ. The patient recovered.

Should this method stand the test of further trials, it is to be preferred to transfusion of blood.

It is, however, adapted to those cases only in which the patient is in danger from loss of blood and the consequent impairment of vascular tonicity from diminished volume of the circulating fluid. The quantity of the saline solution used should not be less than 500 c.c.

The Treatment of Post-partum Hemorrhage.

Dr. MUNDÉ (*Am. Journ. of Obstetrics*): In a case of post-partum hemorrhage

every means at hand should be used to check the flow, beginning with the most convenient one. Thus vinegar, hot and cold water, friction and compression, solution of iron, and electricity, will at times all prove efficacious. He had used a weak solution of iron once, tincture of iodine twice, and in one case compression of the placental site between the fist in utero and the other hand outside for more than two hours before he dared withdraw his hands; all these cases recovered. But preventive means were really the important point in the consideration of this accident. Several rules should always be observed: (1.) Always keep the supporting and compressing hand on the fundus uteri from the moment the head appears at the vulva until the placenta has been expelled. (2.) Do not hasten the expulsion of the placenta too much, but by steady gentle friction of the fundus endeavor to secure its total spontaneous detachment, the occurrence of which can easily be detected by the uniform, firm outline of the contracted uterus on palpation. (3.) Always watch the uterus by the hand, using gentle friction for at least an hour at intervals before leaving the patient. (4.) Always give ergot by the mouth as soon as feasible after the birth of the child, and if the labor has been unusually tedious, or chloroform has been given for an operation, give the ergot hypodermically, injecting to the depth of one inch near the umbilicus. It is well to have the hypodermic syringe ready filled for every labor. (5.) Always have hot water on hand. (6.) Always make sure that the uterus contains no coagula. If these rules are observed, a serious case of post-partum hemorrhage will be very rare.

[Ligation of the vessels by firm and persistent contraction and retraction of

the uterine muscular structures lies at the foundation of all safe methods for the arrest of post-partum hemorrhage. This fact is the thread upon which the obstetrician should string his therapeutic proceedings for the control of hemorrhage after labor. Indeed, the practitioner, who thoroughly comprehends this underlying principle is already well armed for the emergency. The injection of iron solution I believe to be a dangerous and unnecessary procedure. In extreme cases where other means have failed I have ventured to swab the uterine cavity with a mass of cotton, wet with an iron solution, and well pressed out. I have had no occasion to regret this practice, but have followed it on the next day with an antiseptic intra-uterine douche. Tincture of iodine, used in the same manner, as the iron solution, is, perhaps, safer and equally efficient. In either case the cavity must first be thoroughly washed by the injection of hot water. The local use of styptics is justifiable, however, only as a last resort, and is very rarely called for.] J.

Induced Abortion—Method of Operating.

J. AHLFELD (*Archiv. f. Gynaek*) recommends the use of tents with blunt ends, continued till the membranes present. He aims thus to expel the ovum entire. This method, conjoined with the use of antiseptic injections, he prefers to puncture.

Vomiting of Pregnancy.

At a recent meeting of the Obstetrical Society of Boston (*Boston Medical and Surgical Journal*), this interesting subject was under discussion. Dr. Fifield said that for years he had succeeded in controlling the vomiting of pregnancy, either with bromide of potassium or rectal injections of one-half drachm of

chloral hydrate. But recently he had a case under observation in which these measures, as well as others tried, utterly failed to give relief; the trouble growing daily worse, until the woman vomited blood. He then introduced Sims' speculum, drew down the cervix, which was found a little excoriated, and covered it thoroughly with nitrate of silver. Bromide of potassium was then given in ten grain doses every two hours. The next day the patient was well.—*Med. and Surg. Reporter*.

[Prof. Fordyce Barker's method of administering the bromide in carbonic acid water, one drachm to the siphon, is worthy of note in this connection. Vichy water is perhaps a still better menstruum.] J.

Treatment of Extra-Uterine Pregnancy.

Dr. LUSK (Boston *Med. and Surg. Journal*) cites several cases of extra-uterine pregnancy in which faradization and galvanism have been effectually used.

In the larger number the faradic current was employed, and of these his own case was one. Faradization in extra-uterine pregnancy was first successfully used by Dr. J. G. Allen, who reported in 1872 two cases of recovery through its instrumentality. So far, since then, his method, faithfully carried out, has proved uniformly successful, has presented no drawbacks, and all the women are known, from private inquiry, to be enjoying good health at the present time; while of one hundred and fifty cases of tubal pregnancy collected by Henning only seventeen survived.

Laparotomy for Extra-uterine Pregnancy.

Dr. C. LITZMANN (*Archiv. for Gynak.*, XVIII., 1, 1881) records a successful case of laparotomy, for extra uterine-

pregnancy. The gestation was of the tubal variety, and proceeded to term.

The operation was undertaken nine months after the death of the fœtus, and was done with antiseptic precautions.

The placenta appeared macerated, and the soft parts of the fœtus gave way easily under the traction. The entire sac was removed, being only slightly adherent except by a pedicle-like attachment to the right broad ligament. This was tied in divisions with a catgut ligature, and its cut surface cauterized with carbolic acid.

The incision was dressed after the manner of Lister. The convalescence was interrupted by a mural abscess, which the author imputes to the silk sutures used in closing the incision.

The case should teach us, he thinks, that it is not so extremely rare for a tubal pregnancy to advance to full term, and that we should take this possibility more into account in practice.—*Cin. Lancet and Clinic*.—*N. Y. Med. Jour. and Obstet. Review*.

External Version.

The conclusions of Dr. HUBERT (*Lyon Medicale*) regarding version by external manipulation, upon the experience of thirty-four trials, in all but one of which he was successful, are as follows: 1. External version should be done before labor begins, or as soon as possible after it has set in. 2. It may be practicable, however small the amount of liquor amnii, and sometimes even after its escape. 3. As a rule we should bring down the pole of the fœtus which is nearer to the centre of the pelvis. 4. The mother's abdomen should be relaxed to the utmost, and the manœuvres should be practiced in the intervals between the pains. 5. The contra-indications of the operation are few, and its advantages are indisputable.—*Cin. Lancet and Clinic*.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Iodoform in Gynecology.

DR. FRANK P. FOSTER (*New York Medical Journal*) discusses the use of iodoform in gynecological practice, especially in pelvic peritonitis and cellulitis of a chronic form. The cases are classified according to the abnormalities ascertained to be present: First. Cases in which inflammatory action was supposed to exist, or to have existed, but in which the uterus was freely movable without pain. Second. Cases in which the mobility of the uterus was but slightly, if at all, impaired, but in which motion of the organ was painful. Third. Impaired mobility of the uterus, with little or no pain on moving it. Fourth. Mobility of the uterus decidedly impaired, with pain on moving it. Fifth. Uterus nearly or quite immovable, with little or no pain on attempting to move it. Sixth. Uterus nearly or quite fixed, with decided pain on attempting to move it. Seventh. Cases of palpable inflammatory deposit. The most prompt and satisfactory results were obtained in the last group of cases, those of palpable pelvic exudation. Such cases, however, do better, according to the author's experience, under the more usual methods of treatment, than those in which the exudation is not capable of detection by palpation, but is inferred to be present from conditions that can scarcely be explained on any other theory.

But, while such is the case, it is quite as true, he remarks, that now and then are met with bulky exudations which prove utterly rebellious to treatment.

A good deal depends, no doubt, upon whether the deposit is of recent or of remote formation; and this question it is not always easy to settle in the cases of patients of whose past history nothing is known beyond what is elicited by questioning them. Taking the seven groups together, he claims that the patients progressed more satisfactorily, on the whole, than they would have done without the use of iodoform. It is true, he adds, that in the great majority of them hot-water vaginal injections were prescribed, but it is no less a moral certainty that in many instances they were neglected by the patients. Their proper use being assured, he would esteem the three great remedies for chronic extrauterine pelvic inflammation in the following order: First. Hot water. Second. Iodoform. Third. Galvanism. As to the best method of using iodoform in such cases, his preference is for its application to the upper part of the vagina, and he tampons the whole vaginal canal with wicking. This prevents the application from being washed away with the discharge, and the tampon is often of great service by its mechanical action, steadying the uterus, sometimes exerting a gentle even distension upon the deposit, and perhaps inducing a muscular contraction. These tampons are almost always borne without pain or discomfort, and, from the fact that iodoform is analgesic and antiseptic, they may be retained for several days. He usually, however, directs their removal at the end of thirty-six hours. Not the least of their merits is that they effectually shut in the abominable odor of the drug. Used in this way, he has never known iodoform

to betray the patient by its odor, although its taste is sometimes complained of immediately, showing that the substance makes its way into the uterine canal, or else is absorbed by the vagina more promptly than is expected in the case of medicaments introduced into the vagina. For occasional use, as an anodyne; in acute cases, in which the patients are not likely to be asked embarrassing questions by strangers, and in which, as well as in cases of vulvar hyperæsthesia, it is an object to avoid meddling with the genital canal; also with patients who cannot have continuous treatment by the physician himself, the employment of rectal suppositories is a valuable resource.

Iodoform in Gynæcology.

Professor BANDL, of Vienna, uses iodoform in every possible variety of chronic pelvic peritonitis, and with the most satisfactory results. It is used in emulsion with glycerine (1 to 10), and is introduced in the vagina in small quantity on a cotton tampon, where it is allowed to remain from 12 to 24 hours.

In Carl Braun's clinic, iodoform was used experimentally in acute post partum perimetritis with enormous effusion. The abdomen was painted with glycerine emulsion, and the effect was excellent, the effusion being rapidly absorbed. He ascribes the effect partly to the inhalation of the iodine vapor.—*Physician and Surgeon*—*Western Medical Reporter*.

Prolapse of the Ovary; Hysterical Attacks; Treatment of Hysteria.

Clinical lecture by Prof. GOODELL (Med. and Surg. Reporter.)

The next patient has been lately admitted. She was sent to me with a note from a lady who is eminent for her kindness to the poor, with the request that I

should admit her. She is twenty-nine years old; she is pale and anæmic. She has had four children. Her health began to fail after the second labor, which occurred eight years ago. She is regular at her monthly periods. They sometimes last for a day, then stop, and again come on for half a day. She has not lost too much since her marriage, but before that she lost a good deal. She has severe spells, which are so bad that her friends think she will not live through them. These are accompanied by a feeling of suffocation, pain in her heart, pain in her womb and an inability to lie in bed. She has to work very hard, and she tells me that she has a good deal on her mind. The symptoms thus far are those of a neurosis.

I shall now try to find out what is the matter and what can be done for her relief. I find behind the womb a little body, and pressing on this I give the woman great pain. There are some fragments of fæces in the rectum, but when I press backward on this body it slips from under my finger, giving her a great deal of pain. I think, then, that we have a prolapsed ovary, to begin with; further examination confirms me in that belief. There is a slight laceration of the cervix, but that does not cause the trouble of which she complains.

I shall now pass the sound. For the comfort of one or two gentlemen who could not introduce the sound in the ward class the other day, I will tell them that I cannot get this into the womb. The pain that she now complains of is purely nervous, for I am not hurting her at all, as I have not gotten past the internal os. I have now passed it in. The womb is in a good position. It measures 2.5 inches. There is a slight erosion (The patient was now removed.)

This is a case that nineteen out of twenty physicians would say was suffering from disease of the womb. They would treat her for this erosion. She would go from one to another, and they would make various applications to the womb, but she would get no better. That is not the kind of treatment she needs at present, although that will do some good. The trouble with this woman is that she is below par, her nervous system is exhausted. She says that she has a great deal of trouble. I do not know what it is. Her husband may be intemperate. Her husband may be unfaithful to her. She is in a state of high nerve tension, pale and anæmic. She made a great fuss when I knew that I was not hurting her, but I did hurt her when I pressed on the prolapsed ovary. Why is it prolapsed? It is prolapsed on account of her general condition. All the organs suffer, but the ovaries and the womb, the reproductive apparatus, which is the most exacting during menstrual life, suffer the most. The spinal cord also sympathizes, and we have irregular distribution of blood, congestion and anæmia. In other words, as I sometimes illustrate it, we may have blushings and blanchings, as we have on the surface of the body, occurring in the womb. I am afraid, I become pale; I am ashamed, I grow red. What are these? They are produced by emotion. They are due to mental action on the nerves, and then the action of the nerves on the blood vessels. So it is in this condition. These blushings and blanchings are not on the surface but in the internal organs. That womb is blanching, and again it is blushing. The same thing is occurring in that spinal column, in that heart. This is a mere illustration, but when you ask me what is the disease, what is its pathology, what it really is, I will be

hanged if I can tell you. The woman in this nervous condition has no control of herself. Her nerves are not in a state of equilibrium. They are in a state of uncontrol. They are no longer acting harmoniously. One side of the brain is acting more than the other. One set of nerves is acting differently from the others. They are not pulling together, and the result is that we get these conditions of spasms in which her friends think she is going to die. If her friends did not think so she would get over them more quickly. The symptoms are alarming. You will be called to a woman in spasms, and in nine cases out of ten they will be hysterical; but you must not make a mistake. They may be epileptic convulsions, or due to uræmia. There is one symptom which I think that you will not find in other forms of spasms, *i.e.*, tremulousness of the eyelids. The eyelids will be closed but they will be tremulous. When you have this symptom you can safely consider the spasm due to hysteria. I know of no other way of distinguishing hysteria by a glance except the general appearance of the patient, and this can only be learned by experience.

What is the best thing to do in a hysterical convulsion? The best thing to do is to give her a shock, mental or physical. If you are plucky enough to throw a bucket of water over her, she will recover very quickly, but you will probably be shown to the door by the irate father and mother. A good method of producing a shock is to place a piece of ice over the ovarian region or at the nape of the neck. The girl gasps and at once the state of fixity is removed. If you would administer two teaspoonfuls of Hoffman's anodyne, or a drachm of the milk of assafœtida put in the bowel, would probably relieve the condition; but you wish something that

will act a little more promptly. My advice is to get down an emetic, if you can. I do not think it possible for any woman to be hysterical when suffering from nausea. If the throat is so rigid that she cannot swallow, give the emetic by the bowel. If you let a woman see that you are not scared worth a cent, she is going to get over her spell very quickly. If she can have the whole house anxious about her, it is nuts for her to crack; and if she can frighten the doctor, it is the biggest nut of all. If you are the old and tried physican of the family, you might remark, so that the woman can hear you, "If she don't get better soon, I shall have to heat that poker red hot and put it on her spine; that spine is in a very bad condition." I venture to say that there is not one woman in twenty who will not begin to get better. I do not advise you to do it, however. It would be like throwing a bucket of water over her. The father would, probably, invite you to the door.

Make a powerful impression. If an emetic fails, use Hoffman's anodyne. This is really a good remedy. It is a diffusible stimulant, more powerful than valerian, with which it is sometimes combined. As I say, give an emetic, if you can, for a woman must be very plucky if she can go through the nausea produced by an emetic and keep up her hysteria.

Ovariectomy.

In the course of a case of ovariectomy reported in the *Boston Medical and Surgical Journal*, Dr. WALTER F. ATLEE thus summarizes some of the points necessary for success in this operation, with which he has had so much experience as to entitle his remarks to great consideration. In order to avoid any delay, he gives written directions to the patient to have ready—

"Two basins, a bucket, a tin cup, a small tub, a pitcher of hot water, towels, cotton, or carbolized tow, one and one-half yards of flannel, large pins, a package of patent lint, ice, brandy, a feeding cup (or a glass tube, bent), one ounce of chloroform, eight ounces of ether, bottles of hot water, adhesive plaster and a patent ironing table."

The patient must have on a night dress and warm woolen stockings. The day before the operation a dose of castor oil is to be given and nothing to eat afterwards, only barley water. On the morning of the operation, an enema of warm water is given. In performing the operation, the patient, having her night dress drawn up above the waist, her feet protected by woolen stockings and her lower limbs covered by a double blanket, is placed upon a patent ironing table, which being just large enough for the patient to lie upon, allows the greatest liberty to the surgeon and his assistants. The table is covered with blankets to make it comfortable for the patient. The knees and elbows are secured by a roller bandage, so as to prevent struggling. A rubber blanket with a large central opening is then thrown over the patient, the edges of the opening being secured to the abdomen by soap plaster. Ether and chloroform, principally the former, are used to anesthetize. The patient is now ready for the operation. The carbolic spray is not used, but the raw surface of the pedicle is cauterized with carbolic acid. The sponges are washed in carbolized water. A tablespoonful of brandy is given just before the etherization is commenced. If there is much pain or restlessness after the operation, a pill containing 1-8 grain valerianate of morphia is given and repeated if necessary, once or twice on the succeeding day. The diet should consist of milk and beef

tea. Dr. Atlee orders the beef tea to be made as follows: one pound of lean beef steak is cut up small and soaked in cold water, then gradually brought to a boil and boiled for fifteen minutes, then skimmed, strained and seasoned.—*Ibid.*

Ovariectomy During Pregnancy.

Dr. GOLENTAUX reported two successful cases performed by himself. The patients were exhibited to the Royal Academy of Belgium. In one case the child is still in utero and shows signs of life, and it is probable that it will reach maturity.—*London Lancet.*

Is the Ovarian Cell Pathognomonic.

Dr. W. A. EDWARDS, of Philadelphia, concludes after examination of the fluid in three hundred cases, that the granular cell is not pathognomonic of ovarian tumors. The doctor has found the same cells in pus taken from stumps after amputation. He also finds them in fluid taken from the abdominal cavity. However, it is of some value in diagnosis of ovarian cystoma.—*Amer. Jour. Med. Science.*

Extirpation of the Ovaries for Insanity.

In the *American Journal of Insanity* Dr. WM. GOODELL contributes an article from which we extract the following:—

By the aid of Listerism, abdominal surgery has reached such a pass that many formidable operations involving the hitherto sacred peritoneal cavity are daily undertaken, with a success and a degree of safety as much assured as in surface surgery. Even exploratory incisions are boldly made, merely for diagnostic purposes. Hence it is that ovariectomy is now one of the most successful of the major operations. Hence it is that oöphorectomy, or the extirpation of the ovaries—not for any intrinsic

disease, but merely to bring on the climacteric—has been placed on a firm basis.

The disorders of menstrual life for which the ovaries have been successfully removed are fibroid tumors of the womb, chronic pelvic peritonitis, persistent ovaritis and ovaralgia, ovarian epilepsy, dysmenorrhœa, menorrhagia, and, in short, for all those lesions which are brought about or which are intensified by the periodic congestions of menstruation.

To this list there can be no doubt that some forms of insanity ought to be added. The relation which they bear to menstruation is often a very close one—so close, indeed, that the term ovarian insanity would best define it. Thus all alienists have observed cases of mental disorders in which the periods of exacerbation correspond to those of menstruation. In the interval between the monthly fluxes the patient may be either wholly sane or at least quite controllable. Esquirol and Morel have gone so far as to assert that derangements of menstruation form the source of origin of one-sixth of the cases of insanity due to physical causes.

Now, it seems to me that since the verdict of the profession is largely in favor of the removal of the ovaries for many physical derangements dependent upon menstruation, the same remedy should, *à fortiori*, be tried for those mental derangements which plainly arise, or seem to arise, from the same source. The objections to such remedy when applied for mental diseases are, in fact, less valid than when it is resorted to for physical lesions. For, in the first place, an insane woman is no more a member of the body politic than a criminal; secondly, her death is always a relief to her dearest friends; thirdly, even in case of her recovery

from her mental disease, she is liable to transmit the taint of insanity to her children, and to her children's children, for many generations. The removal, therefore, of the ovaries in such a case would then tend to restore a woman to home and to society, and it would at the same time effectually bar her from having an insane offspring. I am, indeed, not sure that in the progressive future it will not be deemed a measure of sound policy and of commendable statesmanship to stamp out insanity by castrating all the insane men and spaying all the insane women. But laying all speculation to one side, I wish now to give my own limited experience in the matter, and to put it on record, so that others may profit by it.

He then records the histories of four cases in which the operation afforded relief. The relief is not immediate, but requires time, and for a cure it is necessary that the patient should be afforded change of scene and occupation in connection with the operation.

In conclusion, he says: "Let me make a few remarks about the mode of performing oöphorectomy. Until very recently I have warmly advocated the removal of the ovaries by the vaginal incision, and, indeed, I would now perform the operation in that way were the ovaries so low down in Douglass' pouch as to be readily felt through the walls of the vagina. But the dangers and difficulties of such an operation, when the ovaries are high up, more than counterbalance its advantages. Twice have I failed to remove them per vaginam, and had to resort to the abdominal incision; and once, from the return of menstruation, I think that some ovarian tissue was left behind. For these reasons, and also because I have found so little inflammatory reaction following the larger operation of ovariectomy, I

shall in future perform oöphorectomy by the supra-pubic incision, unless the ovaries are low down.

Oöphorectomy in Intermenstrual Pain.

An interesting and instructive case is recorded by FEHLING (*Archiv für Gynäkologie.*) The patient was aged thirty-one, married for eight years, but sterile. Menstruation was painless, but the patient suffered from severe pain, which came on from fourteen to sixteen days after one menstrual period, and lasted till three days before the beginning of the next. The cervix uteri had been incised and dilated, the uterus had been depleted, the patient had tried one of the bath cures, but without benefit. She had had an attack of scarlet fever, during which the pain was connected with the maturation of Graafian follicles, and therefore spaying was advised, Dr. Hegar concurring with Dr. Fehling. The operation was performed in June, 1880, both ovaries being completely removed. The patient recovered. The ovaries possess an unusually tough and hard tunica albuginea, and the number of follicles was unusually small; but macroscopic and microscopic examination failed to detect anything else abnormal about them. The patient left the hospital about four weeks after the operation, and remained well for six or eight weeks later. Then the pains began to return, and soon became as bad as ever. Hæmorrhage similar to that of menstruation also recurred. The patient, therefore, was not benefitted by losing her ovaries. This case shows the necessity for caution before assuming that benefit immediately following the extirpation of the ovaries will be permanent. Only in cases which have been watched for a long time can it be safely said whether

they have been cured or not.—*Chic. Med. Review.*

Remedies in Vagina.

DR. SEXTON, (*Med. Record*), reports cases where medicines put in the vagina or ear were tasted in the mouth.—*Det. Clinic.*

Treatment of Enlarged Uterus by Massage.

DRS. PRINCE and REEVES JACKSON of Illinois both advocate the above treatment and claim great benefit from it in most uterine enlargements.—*Ibid.*

Medical Treatment of Uterine Fibroids.

The medical treatment of fibrous tumors of the uterus is not absolutely fixed; subcutaneous injections of ergotine as a continuous treatment would be difficult to carry out, and electricity, which in the hands of M. Chéron has given good results, cannot be conveniently employed in private practice.

M. Chéron in the *Revue Méd Chirrug. des Maladies des Femmes*, remarks that in many cases we will be obliged to have recourse to remedies which calm the pain and uneasiness felt in the abdomen and to others having a resolvent action on the tissues of new formation.

For the first purpose he has found an ointment containing belladonna of great service, acting as a sedative and at the same time reducing the peripheric engorgement and causing a diminution in the volume of the tumor. His ointment is composed as follows:—*R.* Ext. digitalis, 3 j.; ext. belladonnæ, 3 ss.; ung. simplicis, 3 xss. M.

A portion of this ointment as large as a nut should be rubbed in over the abdomen night and morning.

The following solution has a decided resolvent action on tissues of new for-

mation, and at the same time, as shown by Liegeois, a reconstituent action on the entire system:—*R.* Hydrarg. bichlorid., gr. ss.; Aquæ destil., $\frac{3}{4}$ viij. M.

A tablespoonful of this solution should be taken before each meal.—*Med. and Surg. Reporter.*

Treatment of Uterine Fibroids.

Fibroids of the uterus may often be successfully treated by the use of suppositories of ergotin, made according to the following formula:—*R.* Ergotin, gr. 1-12; ol. theobrom., gr. xxij.; vaselin., q. s. for one suppository.

These suppositories are useful also in cases of menorrhagia, metorrhagia and chronic metritis.—*Le Progrès Medical, London Pract.*

Fatal Peritonitis from a Vaginal Injection of Acetate of Lead.

The following case, reported in *Paris Médical*, seems to be in favor of the now generally contested possibility that a fluid injected in the vagina may find its way into the abdominal cavity, through the Fallopian tubes.

A woman, 22 years old, was suffering from a severe attack of leucorrhœa. Injections of acetate of lead were prescribed, and these were continued for ten days, with good results. On the eleventh day the injection was taken rather hastily, owing to some interruption, and immediately after the woman complained of violent pains in the abdomen; she became deathly pale and fainted. Dr. Baum, the attending physician, was called in, and diagnosed acute peritonitis, from which the patient died, seventy-two hours after. The autopsy showed that, besides the ordinary lesions of peritonitis, a precipitate of sulphate of lead had been formed on the entire serous surface of the large intestine and across the whole hypogas-

trium, even as high as the umbilicus. This precipitate had the appearance of small, grayish-black, round peas, which, in some places, were very thickly distributed, while in others only a few could be seen.—*Med. and Surg. Reporter*.

Spontaneous Rupture of an Imperforate Vaginal Membrane.

Dr. MORRIS reported the following case:

A girl of 16 had suffered for the past two years from severe monthly pains in the abdomen—much increased during the last six months. She was thin, emaciated and had symptoms of hectic fever. Upon examination a vagina one and a half inches in length and terminating in an imperforate membrane was discovered, but no hymen. The clitoris was very small, the external genitalia illy developed. He thought he could feel the uterus through the rectum. An operation for her relief was advised but refused. A few days ago the patient was awakened by the discharge from the vagina into the bed of a mass of black blood. Ulceration had taken place through the imperforate membrane, giving exit to the imprisoned menstrual secretion.—*Maryland Med. Journal*.

Medicated Vaginal Pessaries in Chronic Inflammation and Induration of the Labia Uteri.

R. Plumbi iodidi, grs. 80; ext. beladonnæ, grs. 24—40; ext. conii, grs. 100; olei theobromæ, $\frac{3}{4}$ 1—1½; olei olivæ, 3 2. M.

Melt into a mass with gentle heat, pour into a tube or roll of paper about eight inches long and of the circumference of the little finger. Divide into eight pessaries and order one to be introduced into the vagina every night or every other night.—*Med. Gazette*.

Susceptibility of the Uterus.

Dr. VERNEUIL (*Maryland Medical Journal*) calls attention to the fact that although the uterus can generally be subjected with impunity to the most varied operations, there are certain women in whom a peculiar susceptibility exists, and the most insignificant operations lead to grave accidents. A fatal peritonitis has been known to ensue from the vaginal touch alone. Dr. Verneuil cites two cases of death in women the subjects of cancer of the uterus; in one an application of perchloride of iron had been made; in the other the part had been lightly touched with chromic acid in order to check fungous projections. After the most simple surgical interference with the uterus it is therefore best to take minute precautions to avoid these possible accidents.—*Chic. Med. Review*.

Prolapse of the Urethra in a Young Girl.

Dr V. INGERSLEY reports the case of a girl ten years of age, who attempted to stop laughing by stuffing a handkerchief into her mouth. She immediately had a sensation as if something had broken between her thighs, and soon afterward felt something which was not there before. The labia were separated by a reddish blue tumor, the thickness of the end of the index finger, about a centimetre in length, with an opening at its free end. There was a frequent desire to urinate. The mucous membrane was easily reduced under chloroform, but gradually reprotruded. Reposition was effected, tannin was applied and the vagina was tamponed. Prolapse again occurred. A soft catheter was then introduced, passed through a cork which was secured close to the urethral orifice. The prolapse still recurred. The protruded portion was then cut off and four sutures

were passed, so as to sew the urethral orifice to the mucous membrane of the vulva, and a soft catheter introduced. The sutures were removed in eight days, at which time there was no prolapse. Ten days later, another prolapse, 1 ctm. in length, occurred. This was cut off without suturing, and no catheter was introduced. Eight days later the wound had healed and the prolapse has not recurred.—*Hospitals-tidende and Nordiskt Medicinskt, Arkiv., Med. Record.*

Sutures in Recent Ruptures of the Perineum.

Dr. VEIT advocates the immediate union of even the lesser ruptures of the perineum. To accomplish this there is need of no elaborate armamentarium—only needles and scissors are necessary. Dr. Veit recommends to begin at the perineum with the sutures; avoid deep vaginal sutures, and all superficial ones are unnecessary. After bringing the rectal mucous membrane together, the needle is passed through the perineum behind the frenulum and carried along parallel to the rupture in the vagina to the end, where it is brought through the skin. Other deep sutures can be entered under this; superficial stitches, if necessary, are placed between the deeper ones. Chloroform is only necessary in cases that are not operated upon immediately post partum.—*St. Louis Med. News.*

Treatment of Spasmodic Dysmenorrhœa and Sterility by Dilatation of the Cervical Canal with Graduated Bougies.

Dr. GODSON (*London Lancet*), in a paper upon this subject, read before the Obstetrical Society of London, presented notes of five successful cases, in which natural menstruation followed the use of the bougies, and pregnancy occurred within a few months. Five other cases thus treated had resulted less en-

couragingly, although the dysmenorrhœa was of the kind known as spasmodic or obstructive, characterized by severe colicky pain in the hypogastric and sacral regions, either before the menstrual flow or coincident with it. The author preferred to drop the title obstructive, as he knew no evidence to prove that there was a want of patency of the cervical canal, and Dr. Duncan had passed a probe into the uterus at the height of the pains without meeting with obstruction. He believed that the spasm of the uterine muscular tissue was of itself sufficient to give rise to the severe pain without obstruction. The author's conclusions were: (1) that the method was simpler and safer than any other proposed; (2) that the dilatation might be performed with safety at the house of the consultant; (3) that a very small amount of dilatation was necessary; (4) that the operation should be performed within a week or ten days after a period; (5) that it should be done not on successive days, as hitherto recommended, but all at once; that the first bougie should be a small one, and that there should not be sufficient difference between the size of successive bougies to cause a splitting of the mucous membrane; (6) that pregnancy appeared to occur on account of the dilatation having cured the condition on which the dysmenorrhœa depended. In none of his cases was there either stenosis or constriction of the canal by acute flexion. The theory of spasmodic constriction being discarded, the author suggests that the impediment was a spasmodic constriction, causing ejection of the semen.—*Cin. Lancet and Clinic.*

Prolapse of the Uterus.

The French gynecologists are treating prolapsus of the uterus by narrowing

the vagina. The mucous membrane is pared off and the raw surfaces brought in contact with sutures. A number of successful cases are reported.—*Virginia Medical Monthly*.

Amenorrhœa.

In amenorrhœa with torpid circulation: *R.* Potassii iodid., gr. xviii to xxx.; ferri et ammoniæ cit., gr. xl.; tinct. nucis vomicæ, 3 j.; infus. quassiæ ad. 3 viij. *M. Sig.*—One-sixth part three times a day.—*Med. Gazette*.

Pencils of Tannin in Chronic Metritis.

R. Tannin, grs. 30; pure glycerine, gtt. 3. Make four pencils, two inches long.—*Bull. Ther. (Bouchardat)*.—*Med. and Surg. Reporter*.

Disturbances of the Nervous System Coincident with the Menopause.

Dr. F. A. CASTLE, in a paper read before N. Y. Academy of Medicine and reported in *Med. Record*, said:

"Most physicians in general practice had met with women, between forty and fifty years of age, who suffered from two to four years with peculiar disturbances of the nervous system coincident with the menopause, namely, 'frequent attacks of *flushings*, or heats,' as Ringer describes them, starting from various parts, as the face, epigastrium, etc., thence spreading over the greater part of the body. 'Sometimes, although the patient feels deeply flushed, the skin remains natural. The sensation of heat may be so urgent that the patient opens her clothes or removes the greater part of the bed covering, and even throws open the window in the coldest weather.' 'These heats may last a few minutes, an hour, or more, and may be repeated a number of times a day. They are generally followed by perspiration, often

profuse; at other times the skin remains dry, and they are accompanied by great throbbing throughout the whole body, followed by prostration. In many cases palpitation or 'flutterings at the heart,' occur on the slightest excitement, or even without apparent cause."

For the relief of these symptoms drastic purgatives, frequent removals from home at short intervals, frequent small bleedings, bromide of potash and nitrate of amyl had been recommended. The bromide of potassium was, perhaps, the remedy most commonly used, but he had not seen much benefit follow its administration. He had used amyl nitrate with benefit occasionally. The remedy which had given him the best results was *arsenic*, Fowler's solution, three to five drops three or four times a day, used with the customary precautions concerning its administration, and continued for a long time. In his experience the patients had been either relieved entirely or the severity of the attacks had been materially lessened.

Menopause:

Dr. FORDYCE BARKER (*Medical Record*), in a discussion of a portion Dr. Castle's paper on the diseases incident to the cessation of menstruation, said:

"Laxatives and purgatives were useful in a certain class of cases and injurious in another. He regarded them as extremely useful where there was a tendency at the climacteric period to plethora, to become stout, and the patients suffered from palpitation and a feeling of pressure in the head, etc. In those cases he ordered the patient to take a saline laxative daily, for a few days, at the time corresponding to that at which menstruation usually occurred. But there was another class—that in which

the patient suffered from cold feet and extremities, face flushed perhaps, tendency to vertigo, had shortness of breath on exercise, sense of depression, etc.,—in which purgatives and saline laxatives would be the worst treatment, but, on the other hand, marked benefit followed the use of the bromide of potassium, eight or ten grains, three times a day, combined with iron—preferably the lactate. With reference to arsenic, there was no remedy more efficient in cases in which a nerve-tonic was needed, and in which the sense of depression and exhaustion were prominent symptoms. It was a remedy which he had used and recommended for many years, and with very satisfactory results. He had found it almost a specific in the class of cases in which there was a small loss of blood daily, perhaps not more than a teaspoonful, but sometimes prolonged for weeks, and accompanied by great depression, though not the cause of it.

Removal of Uterine Appendages for the Arrest of Uterine Hemorrhage.

In the *American Journal of the Medical Sciences* there is an elaborate and interesting paper on this subject, by Mr. Lawson Tait, in which he advocates in the strongest terms the removal of the uterine appendages for intractable uterine hemorrhage. He reports thirty-one cases, in four of which death occurred, while in all the others there was either complete arrest of the hemorrhage, or marked improvement, with the exception of one case, in which he operated for hemorrhage due to malignant disease, a mistake sure to occur occasionally in the most experienced hands. In most of the cases ergot and potassium salts had been used without benefit.

In these cases Mr. Tait apparently demonstrates that, as far as its primary results are concerned, removal of the

uterine appendages for the arrest of intractable uterine hemorrhage is an operation which is quite as easily justified as any of the major operations of surgery, and that as far as its secondary results are yet known, it is an operation which yields abundant encouragement for its further trial.

As conclusions which are indicated, but not wholly proved, the statement may be formulated that removal of the ovaries alone is not sufficient to arrest menstruation, but that removal of both tubes and ovaries does at once arrest it. As far as some of these cases have gone the arrest would seem to be permanent. This conclusion is quite in harmony with what is known of removal of both ovaries for large cystomata, for in such cases the tubes are almost uniformly included in the clamp or ligature, and menstruation is arrested. Three at least of the cases, and probably two others, show that the arrest of menstruation by this means leads, or may lead, to the atrophy of the tumors.

Finally, there is some close connection, here pointed out, it is believed, for the first time, and worthy of very clear study, between uterine myoma and its accompanying hemorrhages, and cystic disease of the ovaries. In two of the cases the cystic disease seemed to be the cause of the hemorrhage, without any myoma intervening.

Another important point, to which attention is drawn by Mr. Tait, and one which deserves close study, is that menstruation and sexual feeling may persist even after the removal of both ovaries; a point which, if correct, would invalidate a reproach which is often urged—one which may be merely sentimental in view of the advantages gained—as to its implying the unsexing of the patient.—*Med. Gazette.*

DISEASES OF CHILDREN.

Sixteen Commandments of the Paris Academy of Medicine.

The Academy of Medicine has condensed into the following sixteen propositions the most important hygienic rules for the care and management of infants. We reproduce them here with the sincere hope that all mothers and nurses will commit them to memory and observe them as faithfully as the ten commandments of holy writ :

1. During the *first year* the only suitable nourishment for an infant is its own mother's milk, or that of a healthy wet nurse. Suckling should be repeated every *two* hours—*less* frequently at night.

2. When it is impossible to give breast milk, either from the mother or a suitable nurse, cow's or goat's milk given tepid, reduced at first one-half by the addition of water slightly sweetened, and after a few weeks one-fourth only, is the next best substitute.

3. In giving milk to an infant always use glass or earthenware vessels not metallic ones, and always observe the most scrupulous cleanliness in their management, rinsing whenever used. Always avoid the use of teats of cloth or sponge so frequently used to appease hunger or quiet crying.

4. Avoid carefully all those nostrums and compounds so liberally advertised as superior to natural food.

5. Never forget that artificial nourishment, whether by *nursing bottle* or *spoon* (without the breast), increases to an alarming degree the chances of producing sickness and death.

6. It is always dangerous to give an infant, especially during the first two months of its life, solid food of any kind

—such as bread, cakes, meats, vegetables or fruit.

7. Only after the *seventh* month, and when the mother's milk is not sufficient to nourish the child, should *broths* be allowed. After the first year is ended then it is appropriate to give light broths or paps, made with milk and bread, dried flour, rice, and the farinaceous articles, to prepare for weaning. A child ought not to be weaned until it has cut its first twelve or thirteen *teeth*, and then only when in perfect health.

8. A child should be washed and dressed every morning, before being nursed or fed. In bathing a child, temper the water to the weather, carefully cleanse the body, and especially the genital organs which require great cleanliness and care; and the head should be carefully freed from all scabs and crusts which may form. Where the belly-band is used, it should be kept on for at least one month.

9. An infant's clothing should always be so arranged as to leave the limbs freedom of motion, and not to compress any portion of the body.

10. An infant's clothing should be studiously adapted to the weather; avoiding at all times, exposure to the injurious effects of sudden changes in temperature without proper covering; but nurseries and sleeping apartments should invariably be well ventilated.

11. An infant should not be taken into the open air before the fifteenth day after birth, and then only in mild, fair weather.

12. It is objectionable to have an infant sleep in the same bed either with its mother or nurse.

13. No mother should be in too great a hurry to have a child walk; let it crawl and accustom itself to rising on its feet by climbing on articles of furniture, or assisted by the arms of a care-

ful attendant. Great care should be taken in the too early use of baby wagons, etc.

14. No trifling ailments in infants, such as colics, frequent vomiting, diarrhoea, coughs, etc., if persistent, should be neglected—a physician's advice should be at once obtained.

15. In cases of suspected pregnancy, either of mother or nurse, the child should be weaned at once.

16. A child ought to be vaccinated after the fifth month, or earlier should small-pox be prevalent.—*New Orleans Med. & Surg. Journal*.

Blisters in Young Children.

M. ARCHAMBAULT (*Journal de Méd. et de Chir.*) points out that blisters should not be used as routine treatment in children, as they are always painful and often harmful. In a child of a year old, the blister should not be left on longer than one hour; at four or five years, four hours is enough. The blister should be covered with a piece of oiled silk paper. Blisters should never be applied to cachectic children or to those with a tendency to skin eruptions; but above all, blisters should be avoided in diphtheria and croup, and at the terminations of scarlatina, measles, &c., as he has often seen extensive ulcers so caused. Blisters should not be applied posteriorly or to parts exposed to pressure.—*Birmingham Medical Review*.

Carbolic Spray in Croup.

Dr. DESNOS (*Journal de Médecine de Bordeaux*), claims that the carbolic spray, applied directly through the canula after tracheotomy, has a marked effect in producing expulsion of the false membranes.—*Chic. Med. Review*.

Podophyllin and Podophyllotoxin in Children's Diseases.

Dr. BRAUN (*Archiv für Kinderheilkunde*) says that podophyllin in children of thirteen years causes in doses of one-sixth to one half a grain, one to three loose motions frequently preceded by firm motions. The general dose for children under a year is one-thirteenth to one-sixteenth of a grain; for children of one to four years, one-sixth of a grain, and for older children one-third, dependent upon the duration of the constipation. Podophyllotoxin is more certain and is given in doses of one-sixtieth to one-thirtieth of a grain to children less than a year old, and proportionately. It is most conveniently given in solution; three-quarters of a grain are dissolved in one hundred drops of rectified spirit and given in two to ten drop doses in a teaspoonful of syrup.—*Ibid.*

Quinia in the Treatment of Cholera Infantum.

Dr. OTIS T. MANSON, of Richmond, says he has not lost a case of this disease since employing quinine in conjunction with calomel. Quinine is given until full physiological effects are obtained.—*Cincinnati Obstet. Journal*.

OBSTETRICS.

Landmarks in the Operation of Laparo-Elytrotomy.

Dr. WM. M. POLK, Professor of Obstetrics in the University Medical College, New York, recently demonstrated certain anatomical points bearing upon the operation of laparo-elytrotomy, before the New York Obstetrical Society. The specimen shown, taken from the body of a woman who had been murdered in the seventh month of preg-

nancy, was a dissection showing the relations of the pelvic contents during the latter part of gestation, and especially the course of the ureter. Practicing the operation upon this and other cadavers, the author has found that the ureters do not follow the pelvic wall to a point near the ischial spine, as in the non-pregnant condition, but that crossing the pelvic brim at the common iliac bifurcation, the left just behind, the right just in front of that point, they descend into the canal to the brim of the bony pelvis, the point being about the synchondrosis. In this course they accompany the internal iliac artery, the right in front of the vessel, the left crossing it obliquely. Reaching the bony brim (the ilio-pectineal line), they leave the pelvic wall, emerging from beneath the base of the broad ligaments (in pregnancy about on a level with the pelvic brim, and carried back on a line with the synchondrosis), and take a course downward, forward, and somewhat inward, passing about midway between the pelvic wall and the cervico-vaginal junction, but approaching very closely the antero-lateral wall of the vagina, as they turn more decidedly inward, on a lower plane, to strike the base of the bladder three-quarters of an inch below the cervix, terminating in the bladder at a point (the subject being on the back) just two inches below the spine of the pubes. A line drawn from the bifurcation of the common iliac to the spine of the pubes corresponds in the main to the line of the ureters. Along this line they have the following relations to the pelvic brim (in the recent state): At the bifurcation, half an inch below, at the extremities of the transverse diameter of the pelvis, about an inch; and at the spine of the pubes, two inches below. As a whole, the tubes in the pelvis are situated upon a higher plane than in the

non-pregnant condition, having been carried slightly upward while being separated from their close relations with the pelvic wall by the ascending uterus. How far they may be elevated in a case of extreme pelvic deformity with a pendulous abdomen, and the uterus correspondingly displaced, the author is unable to say, but thinks it probable that, the bladder being empty and not dragged upward, thus preserving the normal condition of the vesical end of the tubes, the displacement would not be such as to bring any part of them much above the points above indicated.

Another matter which Dr. Polk took occasion to investigate was the ground of the objection to operating upon the left side. In view of the strong probability that the operation can be done on the same side but once, this, he remarks, is a very important question. He did the operation upon the left side, the vessels being injected with plaster and the rectum distended. He found that the rectum offered no such obstacle as is commonly supposed, and that the operation was as feasible upon one side as upon the other. After the operation the organ was carefully examined, and found in no way disturbed. In looking at its position this was easily accounted for; it lies behind the broad ligament. In entering and leaving the pelvic canal we cross the brim between the base of the broad ligament and the posterior surface of the bladder. This latter is about on a line with the ilio-pectineal eminence, while the former is as far back as the synchondrosis; here is ample space for manipulation and extraction.

The important structures that Dr. Polk regards as most likely to suffer are the vessels going to the uterus through the broad ligaments. These, by being stretched and dragged upon in extrac-

tion, might be torn if the sides of the incision were not carefully supported in cases requiring powerful traction.—*Det. Clinic.*

Laceration of the Cervix Uteri in Abortion.

At the April meeting of the Boston Medical Society for Medical Improvement, Dr. C. M. GREEN reported a case which was interesting from its bearing on the aetiology of laceration of the cervix uteri. The patient was three and one-half months advanced in her first pregnancy. Pains severe. Morphia given in large doses prevented sensibility, but uterine contractions continued. Os dilated to one-half inch in diameter. The fœtus was expelled in one hour, and examination showed rupture of cervix and the pericranium of fœtus was torn off from the occiput, showing obstruction. This case affords fresh illustration of laceration as a consequence of abortion from rigidity of cervix.—*Boston Med. and Surg. Jour.*

Female Mammary Gland, Relation between Tumors of.

Dr. S. W. GROSS, (*Medical News*), from an elaborate study of this subject obtains the following results:

1. That from a genetic standpoint there is a distant connection between adenoma and carcinoma, since they both originate from the glandular constituents of the mamma. In the former neoplasm however, there is a numerical increase of the lateal glands; in the latter, there is merely a multiplication of the epithelial cells, which extend into the lymphatic vessels and the perivascular sheaths of the bloodvessels. From a clinical standpoint, adenoma is a benign tumor, and carcinoma is a malignant growth.

2. That sarcoma has neither a genetic nor a structural affinity with adenoma

or carcinoma, but that it resembles the latter in its malignant attributes.

3. That, in view of the recurring tendency of adenoma after simple enucleation the entire breast should be extirpated with it.

4. That surgical intervention in sarcoma and carcinoma not only retards the progress of the disease by preventing local dissemination and the development of visceral tumors, but it also not infrequently results in permanent recovery.

5. That local reproductions in sarcoma and carcinoma do not militate against a final cure, provided they are freely excised as soon as they appear.

6. That lymphatic evolvment does not forbid operations in carcinoma, since affected glands were removed in nearly one-third of examples of permanent cure.

7. That the subjects of sarcoma and carcinoma are, almost without exception safe from local and general reproduction if three years had elapsed since the last operation.

8. That all sarcomata and carcinomata of the mammary gland, if there are no evidences of metastatic tumors, and if thorough removal is practicable, should be dealt with as nearly as possible by amputating the entire breast and its integuments, and dissecting of the subjacent fascia. In carcinoma, moreover, the axilla should be opened with a view to its exploration and the removal of any glands which were not palpable prior to interference.

Umbilical Hemorrhage.

In an infant three days old the umbilical cord dropped off, and a very severe hemorrhage resulted. The child could neither nurse nor cry without causing a jet of blood. A ligature be-

ing applied, it slipped and became useless. Dr. Fifield thought of using pins and then ligating under them; but the child seemed to be a "bleeder," and had *nævi* in various localities of the body. The proposal was therefore abandoned, it being thought unsafe. The expedient adopted and described by Thomas Day then suggested itself. This procedure consists in pouring a mixture of gypsum into the navel. Dr. Fifield procured plaster of Paris, prepared it, adding salt to make it set quickly, poured it gradually into the umbilicus, increasing the thickness until it had assumed a mound-like form. The bleeding ceased. After a few days the cast fell off, bringing with it the remnant of the cord. The child has continued well.—*Med. Times*.

Antiseptic Action of Phenic Acid in Pregnancy.

Dr. MORRA, of Turin, has used phenic acid as an antiseptic in the form of clysters, in two cases of pleuro-pneumonia and in two cases of puerperal infection. The details of these cases are too long, but the results arrived at are:

That phenic acid administered by the rectum during pregnancy, and during the puerperal state, has antiseptic properties, prompt and sure. Its action is uniform, and is indicated in the temperature, the pulse, and the respiration, and is not of long duration. The remedy can be employed with confidence, and the dose can be safely increased. A dose of 30 grains is sufficient and has no effect on the *fœtus*. In puerperal maladies it has a powerful local action. Its elimination is chiefly by the kidneys, and when the urine is colored black it shows the effect of the drug, and indi-

cates ulceration in the rectum.—*Revista Bologna, Ther. Gazette*.

A Simple Method of Resuscitating a Still-born Child.

In a case in which the child was with some difficulty resuscitated, Dr. JOHN SHRADY was in consultation, and he resorted to the following method with satisfactory results. Place a piece of thin cloth, like a handkerchief, over the mouth of the child, fill the lungs with fresh air, and then gently blow through the cloth, while the nose is held to prevent escape of air, and the stomach is gently pushed in to prevent the air from entering that organ.

A method which Dr. White had very frequently resorted to, with excellent results, was rubbing a small quantity of chloroform along the spine.

Dr. Post referred to the tendency to the occurrence of convulsions within twenty-four or thirty-six hours in resuscitated children. Dr. Sell referred to a case in which he succeeded in restoring the child after working an hour and a half, but it died twenty-three hours afterward with convulsions. It was a case of breech presentation.

Dr. Harwood had found Kidder's "Galvano-Electrical Machine" most serviceable in resuscitating still-born children, applying the current through his own hands placed over the thorax and spine.

[The excellent method adopted by Dr. Shradly will be found more fully treated of in the article on *apnoea* in Holmes Surgery, vol. v.]—*J*.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

A Method of Removing Benign Tumors of the Breast Without Mutilation.

Professor T. GAILLARD THOMAS, Surgeon to the New York State Woman's Hospital, contributes to the April number of the *New York Medical Journal and Obstetrical Review* a paper in which he expresses himself in favor of removing benign tumors of the breast, as a rule, because the mere presence of a tumor in the breast usually renders the patient apprehensive, nervous, and often gloomy, while, with our present improved methods of operating, the patient is exposed to slight risks, the danger of growth of the tumor is removed, and with this disappears at the same time that of the subsequent degeneration of a benign into a malignant growth. If, in addition to these advantages, we can add the avoidance of all mutilation to the person, we have strong grounds for departing from the practice of non-interference. The method of operation described, Dr. Thomas has practiced thus far in a dozen cases. He distinctly states that it is entirely inappropriate for tumors of malignant character, and that it is applicable neither to very large nor to very small benign growths, being insufficient for the former and unnecessary radical in its character for the latter. The growths for the removal of which he has resorted to it have been fibromata, lipomata, cysts, and adenomata, and have varied in size from that of a hen's egg to that of a duck's egg or a little larger. The operation is thus performed: The patient standing erect and the mamma being completely ex-

posed, a semicircular line is drawn with pen and ink exactly in the fold which is created by the fall of the organ upon the thorax. This line encircles the lower half of the breast at its junction with the trunk. As soon as it has dried the patient is anaesthetized, and with the bistoury the skin and areolar tissues are cut through, the knife exactly following the ink-line until the thoracic muscles are reached. From these the mamma is now dissected away until the line of dissection represents the chord of an arc extending from extremity to extremity of the semicircular incision. The lower half of the mamma which is now dissected off is, after ligation of all bleeding vessels, turned upward by an assistant and laid upon the chest-walls just below the clavicle. An incision is then made upon the tumor from underneath by the bistoury, a pair of short vulsella forceps is firmly fixed into it, and, while traction is made with it, its connections are snipped with scissors, the body of the tumor being closely adhered to in this process, and the growth is removed. All hemorrhage is then checked, and the breast is put back into its original position. Its outer or cutaneous surface is entirely uninjured, and the only alteration consists in a cavity at the former situation of the tumor. A glass tube with small holes at its upper extremity and along its sides, about three inches in length and of about the size of a No. 10 urethral sound, is then passed into this cavity between the lips of the incision, and its lower extremity is fixed to the thoracic walls by India-rubber adhesive plaster, and the line of incision is closed with

interrupted suture. In doing this, to avoid cicatrices as much as possible, very small round sewing needles are employed; these are inserted as near as possible to the edges of the incision, and carry the finest Chinese silk. After enough of them have been employed to bring the lips of the wound into accurate contact, the line of incision is covered with gutta-percha and collodion, and the ordinary antiseptic dressing is applied. If the glass drainage-tube acts perfectly there is no offensive odor to the discharge, and the temperature does not rise above 100° ; the tube is in no way interfered with until the ninth day, when the stitches are removed. If, on the other hand, the tube does not appear to perform its function satisfactorily, it is manipulated so as to cause it to drain all parts of the cavity, and warm carbolyzed water is freely injected through it every eight hours. On the ninth day, when the stitches are removed, the tube is removed likewise.

Double Bodied Uterus—Retention of Menses—Utero-Abdominal Fistula Established.

The following case occurred in the service of Dr. T. G. THOMAS, at the Woman's Hospital. The patient, a Frenchwoman, had been suffering for sixteen years from what was supposed to be a fibroid tumor of the uterus. At every menstrual epoch she was tortured with pains which almost drove her to insanity. She had been under the care of a Parisian physician for a number of years, but failed to obtain relief. When she came into the hospital the tumor had attained the size of a child's head. She had always menstruated through the vagina; the uterine cavity measured from two and one-half to three inches. Dr. Thomas declined to remove the growth, thinking that such procedure

would cost the patient her life, in which opinion he was supported by his colleagues, Drs. Emmet and Hunter. The woman, however, persisting in having an operation performed, it was consequently determined to remove both ovaries. The tumor was cut down upon and on examination gave obscure evidences of fluctuation. Upon tapping it with a trocar and canula, *three pints of menstrual blood*, looking like tar water, *were drawn off*. The case proved to be one of uterus bicornis, the cavity of one of the bodies communicating with the vagina, that of the other being closed. For sixteen years she had been menstruating from both corpora; from one the blood escaped per vaginam, from the other it could only be removed by reabsorption; hence the increase in size of the latter body. Diagnosis before the operation was, of course, an impossibility. The corpus uteri, which had been the source of all the trouble, was then fastened to the walls of the abdomen in such a manner as to allow of injection and drainage of its cavity through the abdominal parietes, the canula being kept in place. After the operation the patient developed a low grade of septicæmia, but subsequently improved, menstruated, and is now doing well. In this case it would have been useless to remove only the ovary of the supernumerary body, inasmuch as the woman would nevertheless have menstruated from both corpora at each catamenial period. Dr. Thomas preferred the procedure adopted to that of removing the ovaries, because the former subjected the patient to less risk.—*Med. Record*.

Baker on Vaginal Ovariectomy.

Dr. W. H. BAKER, instructor in gynecology in Harvard University, in publishing the history of a case of vaginal

ovariotomy that occurred in his experience, where the result was fatal, sums up his views substantially as follows: The success now attending ovariotomy by abdominal incision restricts the advantages of the operation to a very limited number of cases, and these should be where the cysts are small and their contents are bland, so that removal can be effected without difficulty and without great danger of septic peritonitis from the escape of any of the fluid into the peritoneal cavity; or in dermoid cysts so small as to be removed through the vaginal incisions without evacuation. On the other hand where ovarian cysts are firmly adherent in the pelvis, drainage into the vagina is recommended, the cyst being either destroyed by the cautery or allowed to suppurate and discharge itself through the line of incision.—*New York Med. Journal.*

Ovariotomy in a Girl.

Dr. W. O. FURGUSSON (*Medical Bulletin*) reports the removal of an ovarian cyst, weighing ninety-nine and two-fifths pounds, from a girl fifteen years of age. The tumor had been tapped at four different times, twenty gallons of fluid in all having been drawn off. When operated on, the tumor presented extensive adhesions to the liver, stomach, intestines, and walls of the abdomen. The patient recovered.

Hernia of the Ovary in the Inguinal Region.

A little girl, aged six months, was brought to the service of Prof. Beckel, of Strasburg, presenting in the left inguinal region a tumor of the size of a pigeon's egg. The skin which covered it was red and inflamed; the tumor itself was hard, very painful and irreducible. It was situated at the external orifice of the inguinal canal. It was perceived

for the first time three months ago, and was then about the size of a nut; and being reduced by a medical man it did not make its reappearance until a fortnight before admission into the hospital.

The child cried day and night, vomited frequently, and got thin. The bowels continued to act tolerably well. On examination, hernia of the ovary was diagnosed, and chloroform being administered, reduction having become impossible, an incision was made over the tumor, dividing the skin and subcutaneous cellular tissue, when the ovary was brought to view, enveloped in its sac. Incision of this sac gave exit to a few drops of colorless liquid. A silk ligature was thrown around the pedicle, which was formed of the fallopian tube. The wound was dressed antiseptically, and at the end of nine days the ligature fell, and the cure was complete at the end of thirty days. The section of that ovary included half an inch of the fallopian tube.—*St. Louis Med. News.*

A Case of Subacute Ovaritis.

The following clinical case is reported by Dr. A. W. FOOT, in the *Dublin Journal of Medical Science*: A young girl (seventeen), Alice G., applied for advice, May 28th, with severe pain in the right iliac fossa, so sharp she "could hardly breathe," and interfering with her standing and walking. She had frequent sickness of stomach, no appetite, moderate fever. This pain had come on suddenly, without assignable reason, on the last day of a catamenial period. There was great tenderness over the right ovary. She was kept in bed, at rest, on her back, with poultices over the seat of pain, and given bromide of potassium (7 grs. three times a day). In a week she got up, at her own request, but was weak and unable to continue long out of bed at a time. She was now given some

wine and a mixture with tartarated iron. She went out well on the 6th of June. This may have been merely ovarian hyperæsthesia, but it was also suggested that it might have been a case of subacute ovaritis, or of local peritonitis arising from the bursting of a Graafian vesicle into the cavity of the peritoneum. Hughes Bennett reports a case of peritonitis from this cause; the patient was admitted into the hospital on the sixth day, and died on the eleventh day. He adds that he has since seen three other cases of the same kind, all of which recovered. In none of these latter, he remarks, were leeches applied.—*New Eng. Med. Monthly.*

Ovarian Dermoid Cysts.

The origin of these has been much disputed, and theories of their formation are very numerous and discordant. Blumenbach claimed that they were the results of an excess of formative nîsus. Waldeyer at one time advanced the hypothesis of parthenogenesis, but abandoned it. Lawson Tait has since adopted the same hypothesis with additions. Heschl claimed that dermoid cysts result from the inclusion of abnormal structures, and from the same being pinched off during fœtal life. This explanation was only made for dermoid cysts, other than those of the testicle and ovary. His extended it to apply to those of the testicle and ovary. Verneuil and Hueter adopt the theory of fœtus in fœtu. Dr. Elsner (*Dublin Medical Science*, May, 1882,) after an extended analysis of cases coming under his observation, and the literature of the subject, says: We know that dermoids occur externally and internally in places where the epiblast dips down to meet the hypoblast, and where by processes of grooved involution new bodies are

formed, such being, first in order, the testicle and ovary, and that therefore they are all embryonal in their first structure. Small at first, they may, under certain conditions, develop to an enormous size, as occurs in the ovary where a periodical afflux of blood goes on after puberty, about which time it is observed that dermoids take on growth. That the occurrence of bone, muscle, and nerve, etc., in genital dermoids is explained by the fact that all three layers of the blastoderm contribute to form the intermediate body (the Wolfian) from which the ovary and testicle become developed, and hence cells belonging to either layer may only too readily be pinched off in the involution process. They are perfectly innocent growths anywhere except in the ovary, and only malignant there as any growth might be. All dermoid cysts are essentially the same. The fœtal remains (properly so called, not shapeless bones) do not point to a formation of fœtus in fœtu, nor are they analogous to dermoid cysts, but are due to analogous process at an earlier stage of embryonic life: Inclusion of one ovum in another, the included becoming part and parcel of the other.—*Chic. Med. Review.*

Use of Pessaries.

Dr. P. F. MUNDÉ, A. M. A., (*Virg. Med. Monthly.*)

Be sure to diagnose the nature and degree of displacement before using the pessary. Replace the uterus. It is well to do this repeatedly, every day, or twice daily, for several days before using the pessary. The objects for so doing are two: to distend and toughen the vaginal pouch (which may be done by means of a cotton tampon), and to relax the over-stretched uterine ligaments.

Never insert a pessary if there be

acute or recent inflammation of the uterus; or when pressure on the part where the pessary is to rest gives decided pain.

When the uterus is not replaceable because of adhesions which bind the fundus down, use great caution and discrimination in deciding whether the fundus is to be elevated by manual and instrumental means or gradually by use of a pessary (this applies only to retro- and latero-versions). If neither is advisable, try to induce resolution of the adhesions by local, alterative, and absorbent measures before using the pessary.

Choose an indestructible instrument. This does not apply to prolapsus uteri.

No two vaginæ are exactly alike. Choose a pessary for, and adjust it to, each particular case.

If the vaginal pouch is too shallow to receive a pessary, deepen it by daily tamponing with cotton or by the upward pressure of a Cutter or Thomas vagino-abdominal supporter previous to using the pessary.

Never leave a pessary in the vagina which puts the walls to a stretch, and which does not permit the finger to pass between it and the wall of vagina (does not apply to prolapsus uteri).

A pessary which projects from the vulva is displaced.

A well-fitting pessary is a source of comfort and gives no pain. Giving pain it should be at once removed.

Always examine a patient on her feet after introducing a pessary to ascertain if it be competent to sustain the uterus during walking, etc.

Always tell a patient that she has a pessary in her vagina when you have put one there, or she may, unconscious of its presence allow it to remain for years to her ultimate discomfort and danger. Always tell the patient to re-

turn within a week after the first introduction that the position and working of the pessary may be looked after. After this let her return every four to eight weeks, or the instrument, if not looked to, may cause ulceration. The patient will have to wear the pessary for months or perhaps years before recovery can be expected. Never introduce a pessary which the patient cannot herself remove, and tell her to remove it whenever it causes pain and present herself at once for examination.

Vaginal injections daily should be used for cleansing purposes; if the discharge be profuse, add astringents; if sanious or purulent, let her come to you at once, as the instrument has probably caused ulceration.

On removing the instrument let the patient test the result of its use. It will take several days, or weeks, to determine the benefit obtained.

Relieve downward pressure by a proper support of the skirts; and in anterior displacements aid the internal supporter by a supra-pubic pad.

All pessaries may be introduced in the knee-chest position when it is desirable or possible to replace the uterus only in that position.

A Sims speculum elevates the perineum, air enters and expands the vagina, the pessary is introduced by touch and sight, and the patient laid over on her left side.

For aggravated retroversion and prolapsus of ovaries or uterus this has many advantages over the left semiprone decubitus. It must be remembered, however, that here the position of the patient is reversed, and that the pessary must be introduced accordingly.—*Can. Med. Record.*

Atropin in Menorrhagia and Hemoptysis.

DR. TACKE (*Berlin. Wochen.; Practitioner*) considers atropin a much more certain remedy in menorrhagia and hemoptysis than ergot. He was led to apply it in these conditions by injecting it subcutaneously in a woman suffering from eczema, and who had at the same time a profuse menstrual flow. He injected 1-200 of a grain twice daily for two days. The eczema was greatly benefitted, and the menstrual flow was much reduced. He recommends a solution of sulphate of atropin one to one thousand of water; five minims to be injected two or three times a day subcutaneously.—*St. Louis Med. News.*

Leucorrhœa from Relaxation of Vaginal Mucous Membrane.

R. Ferri tartarati, gr. 60; spts. ammon. aromat., 3 3; infus. quassia, ad. 3 8. M. Sig.—One-sixth part three times a day.—*Med. Gazette.*

Leucorrhœa.

R. Zinci oxidi vel bismuth. carb., grs. lxxx.; ext. belladonna, grs. xl.; olei theobromæ, 3 j.; olei oliv., 3 iij. Mix.—Divide into eight pessaries, and order one to be used every night.—*Med. Gazette.*

Removal of the Uterus for Cancer.

The November number of the *New York Medical Journal and Obstetrical Review* contains a "special article," by Dr. ANDREW F. CURRIER, of New York, in which the various methods of removing the entire uterus, for cancer, as practiced by Freund, Schröder, Czerny, and others, are reviewed, as well as the general question of the advisability of removing the organ. He thinks the advantages of the vaginal method over that

of Freund (by laparotomy) are enormous; there is but one section of the peritoneum; the intestines are unharmed, there is a better opportunity to discover diseased tissue, which is most likely to be situated in the vicinity of the cervix, and most important of all, the patients often survive, which is rare by Freund's method. But most patients are not likely to be benefitted by either of these serious operations; the most hopeful cases will be those in which the patients are warned of their danger in the early stages of the disease, and in such cases Schröder's supra-vaginal excision of the entire cervix is most likely to prove of service. This operation, while not so radical as removal of the entire organ, and hence not so efficient in cases involving the tissues above the internal os, is far less grave, and is, besides, more thorough than amputation of the cervix as it has ordinarily been done in the past. In those rare cases, however, in which the body of the uterus alone is involved, there is no alternative to laparotomy, either by Freund's operation or some modification of it. As to drainage—a most important item in such cases—a perfect system seems impossible, but Bardenheuer's, although in the hands of others it has not fulfilled its author's expectations, affords as good results as any yet devised. As to the broad question of whether cancer of the uterus, and so cancer in general, can be radically cured, the author thinks the logic of events points to its approaching solution.—*Med. and Surg. Reporter.*

In Amenorrhœa with Hysteria.

R. Ferri valerianat., gr. 18; olei sabina, min. 24; ext. aloes barbadensis, grs. 6; pilulæ assafœtidæ co., grs. 36. M. Divide into twelve pills, one to be taken three times a day.—*Med. Gazette.*

Imperforate Hymen.

Dr. W. G. MOORE says, in the St. Louis *Clinical Record*, that a young girl of seventeen called at his office with symptoms of a malarial attack, for which he gave her appropriate treatment. Three days later he was called to see her, and upon entering the room found her screaming with pain. The mother said that the fever had "settled in Lizzie's womb." Every few minutes she would have a very severe pain in every way simulating labor pains. On attempting to introduce the finger into the vagina it was met by an elastic tumor as large as the vertex of the ordinary foetal head, and having exactly the feel of the protruding membranes when about to rupture. Further inspection revealed an exceedingly thick and resisting imperforate hymen. This was punctured with a bistoury, when, by the aid of a grooved director, the incision was enlarged to the full size of the vagina. The after treatment consisted in rest in bed and carbolized injections. The retained blood in this case was at least a quart.

**A Case of Partial Inversion of the Uterus
Caused by a Fibroid Polyp.**

The tumor at the time of the operation was found to be attached to the fundus to the extent of two inches, and at the time of its removal it weighed one pound and three-quarters. It measured five inches and a half in its transverse diameter, and three inches from above below. It had no pedicle; it exhibited a cup-shaped depression at the point where it was dissected from the uterine wall. The patient was an unmarried lady, aged twenty-four years, who menstruated irregularly during the first six months of her menstrual life, but subsequently her periods were regular up

to the age of twenty-one. From that time menstruation became more prolonged, and she suffered occasionally from metrorrhagia, and sometimes the vaginal discharge was irritating in character. Her health declined rapidly. On several occasions vaginal hemorrhage was profuse. One peculiarity in the case was, that Dr. Reamy was unable to obtain any evidence by physical exploration of cupping of the fundus. He supposed that he had detected the existence of a pedicle, however, before the operation, but at the time of the operation what was supposed to be a pedicle was demonstrated to be only an inverted portion of the uterus. With much difficulty he succeeded in applying the écraseur to what was supposed to be the pedicle of the polyp, but before he was able to complete the operation the chain broke, an accident which he regarded as exceedingly fortunate in view of the subsequent history of the case; for, had it not broken, doubtless he would have removed the inverted portion of the uterus. The case was interesting as illustrating the difficulty of diagnosis, notwithstanding all the improved methods, and showed that there is danger of making the mistake of regarding an inverted portion of the uterus as the pedicle of a polypus. In the light of the present case he should hereafter be exceedingly solicitous with regard to diagnosis, and in the least doubtful cases he should hesitate, and at once quarter the tumor with the scissors and clear up this doubtful point. It seemed to him clear that the tumor was delivered from the uterus on the night previous to the day designated for the operation, and that the inversion which existed in the uterus was not gradual in its origin.—*Amer. Jour. of Obstet.*

Camphorated Chloro-Tannate of Iodine.

The above named preparation to be used as a topical application to bleeding ulcers and cancers of the cervix uteri, is made as follows: *R.* Chloral hydrate 3 i; iodine, 3 ss; oil of camphor, 3 vi. M. S. ft. sol., et. adde. Tannic acid q. s. to bring the mixture to the consistence of thick syrup.

For hemorrhagic ulcers and cancers of the cervix uteri, we have found the above preparation an excellent application, both as a hemostatic deodorizer and alterative. For bleeding cancers, we use the medicine pure, by charging a pledget of candlewick with the mixture, and placing it against the affected part, filling in the vagina below with dry, clean wicking. The application should be renewed every day, as long as hemorrhage threatens or bad odor persists; and before each dressing, the parts should receive a prolonged hot syringe-bath, with a dilute solution of chloride of zinc.

Then more emollient applications—as the comp. iodoform ointment—will be in order.

A good formula for comp. iodoform ointment:—*R.* Iodoform; ergotin; pine tar; balsam, aa 3 i; vaseline, 3 i. M. S. ft. ung.—*Mich. Med. News.*

New Method of Treating Endometritis.

Dr. S. S. BOYD, of Dublin, Ind., in a communication to the *American Practitioner*, says:

Within three years I successfully treated, by a method original with me, a very obstinate endometritis, occurring in a woman twenty-five years of age, who had been married five years. During all of her married life, until recently, she suffered from a constant flow of mucopurulent discharge from the uterus, with all the attendant symptoms of endome-

tritis. Much of the time she was scarcely able to walk about the house. During the two and a half years which I treated this patient, I exhausted all of what I considered safe remedies, both topical and general, with but little benefit. Finally, I adopted the following plan of applying nitrate of silver to the endometrium.

Taking a small female silver catheter I had it cut in two, so as to leave three inches of the closed end in one piece. In three-fourths of an inch of this closed end I had as many small perforations made as could be, without materially weakening the walls of the instrument, and to the outside of the open end a ring was soldered, to which a small cord could be attached. Having on the day previous to that on which I used this instrument introduced into the uterus a slippery-elm tent, retaining it in place by a pledget of cotton wool, I let the tent remain over night. Putting about fifteen grains of coarsely pulverized nitrate of silver in the tube above described, and confining it there by pressing a little cotton on it, I then tied a small cord, six inches long, to the rim, when it was ready for use. Removing the plug and the tent after introducing the speculum, I inserted the silver tube into the uterus, until the distal end reached the fundus, securing it in place as I did the elm tent, leaving one end of the cord outside of the vagina. This was done as a precaution against any serious pain in my absence, in which case the patient could remove the tube. But it was not found necessary to remove the instrument for three or four hours, and then the nitrate of silver was dissolved.

Briefly, the foregoing treatment was that which finally relieved a long suffering patient, in less than six weeks, by four applications one week apart. Of

course, I did not neglect to administer iron, sulph. quinia, ale and ext. malt, as I consider constitutional medication in such cases essential to the relief of the local disease.

As this mode of topical application to the internal uterus was tried in but a single instance, no certain deduction can be drawn as to its general adaptation to the cure of endometritis, and yet, from its complete and speedy success in this single case, I am led to hope it may prove a valuable addition to the local treatment of this form of uterine disease.—*Med. and Surg. Rep.*

Alkaline Treatment of Sterility.

CHARRIER (*La France Médicale*), has recently called attention to sterility produced by a case which he regards as but little known, but which has received considerable attention in the United States, namely, acidity of the utero-vaginal secretions. He concludes, First, that in certain rare cases in a perfectly healthy female, the utero-vaginal secretions may be acid enough to redden titmus paper. Second, that this acidity may prove an obstacle to fecundation, as spermatozoa did in a medium even slightly acid. Third, to remedy this normal acidity of the utero-vaginal liquid, an alkaline treatment (alkaline drinks and baths) should be used, and lukewarm alkaline injections. Fourth, that this acid state having been corrected, and the secretions having become neutral, the obstacle to fecundation is removed, and conception may take place. Fifth, that this disappearance of acidity under the influence of alkaline treatment explains the success with which sterility has been treated at alkaline and sulpho-alkaline watering places.—*Can. Lancet.*

DISEASES OF CHILDREN.

Baths for the Newly Born.

Dr. F. WINCKEL, of Dresden (*Centralb. f. Gynäkol.*), makes the novel suggestion of keeping certain newly born children permanently in warm water. This he considers more useful than rolling them in cotton-wool, applying warm bottles, and keeping them in warm rooms.

The following abnormal conditions are mentioned as being suitable for the permanent bath:

1. Children born between the twenty-eighth and thirty-sixth weeks.
2. Children born asphyxiated and weak from flooding during labor, or who have accidentally lost blood from the stump of the cord.
3. Where there is disease or fretting of the skin.
4. In emaciation, to prevent bed-sores. The author has employed this treatment successfully in cases such as those above mentioned, and gives details of temperatures and results.—*Glasgow Medical Journal.*

Constipation in Infants.

The following are some of the remedies found useful by Dr. D. H. CULLIMORE (London *Lancet*):

1. A pellet of butter and brown sugar or treacle every morning fasting, or a little raspberry jam.
2. The morning insertion into the rectum of a conical piece of white curd soap, about two inches and a half long. It must be first dipped in warm water, held *in situ* for five minutes, and withdrawn.
3. Daily friction over the body, from the right iliac region along the course of the gut, with a salad oil. In India I have used cocoanut oil advantageously.

Cod-liver oil is very useful when its smell is not objected to.

En passant, I may say that I have at present under my care a girl of fifteen who for a couple of months has suffered from obstinate constipation. She has lately had typhoid. Both mild and strong purgatives were ineffectual, and it has now yielded to cod-liver oil friction. Assiduous friction without any unguent is often equally useful. Patience, however, is necessary. A teaspoonful of fluid magnesia in the food is a good plan. Tomato jelly is sometimes used in India with benefit. Whatever plan may be adopted it is well to supplement it with the internal administration of half a drop of tincture of nuxvomica, three times a day; a quarter of a drop is sometimes sufficient. Minute doses of sulphur also answer well.—*Can. Lancet*.

Purulent Infantile Ophthalmia

Is treated by Prof. GOSSELIN, not with astringents but with alcohol and water (3 i.-3 v.) Four or five injections are used daily. Gosselin says that he is never disappointed in the result. We fear other physicians may be. Prof. Gosselin is a sanguine man.—*Med. Record*.

Cholera Infantum.

W. F. HAMER, M. D. (*Louisville Med. News*).

I shall not enter into the general details of this subject, as every practitioner knows what infantile cholera is, but will simply report some cases as they have occurred in my practice.

CASE I.—I was called to see M. E., aged eleven months, July 10, at 10 A. M., and found her vomiting, the bowels acting every ten minutes, the discharges being very watery; pulse 140,

temperature 104°. There was considerable stupor. She was placed in a mustard bath for from six to ten minutes, and afterwards rubbed dry and laid in bed. The following was ordered: Iced gum water freely as a drink alternately with subnit. of bismuth and saccharated pepsin, of each ten grains, given in ice-water every one or two hours. A poultice of mustard and flaxseed was placed over the abdomen and cold applications made to the head. I called at 2 P. M., and found the patient resting easy. The bowels had moved four times, and there had been some vomiting; pulse 130, temperature 102½°; treatment continued. I saw her at 7 P. M.; pulse 130; temperature 102°; had vomited two or three times; bowels had acted three times since 2 o'clock. The bath was again resorted to and the following prescription was given: *R.* Tinct opii deodorat., gtt. x; bismuth. subnit., 3 ij.; syrup. simpl., 3 ss.; mist. cretæ, 3 jss. Mix. Sig. Teaspoonful every two hours alternately with the gum water. Iced brandy was also prescribed.

Called at 6 A. M., July 11th; patient resting easy; treatment continued. Called at 11 A. M. There had been some vomiting, but the bowels were easier; pulse 120, temperature 102°. The bath was again given and treatment continued. At 2 P. M. patient was resting well. At 8 P. M. pulse 130, temperature 102½°; bath again given and treatment continued.

At 7 A. M., July 12th, patient had rested well, vomited but twice during the night; the bowels had moved three times; pulse 115, temperature 100°. At 3 P. M. still improving; medicine to be given at longer intervals.

July 13th, at 8 A. M., still improving. Case discharged.

CASE II.—R. H., aged 14 months. I first saw him on July 14th, at 3 P. M. The

bowels were acting frequently, and the patient had vomited several times; pulse 120, temperature $103\frac{1}{2}^{\circ}$; the stools were thin and watery. I ordered the following: *R.* Bismuth. subnit., \mathfrak{z} ijss; pulv. cret. camph. c. opii, \mathfrak{z} ss; pepsin sacch., \mathfrak{z} ij. Mix and divide into ten powders. One powder to be taken every two hours in ice-water alternately with gum-water. A poultice of flaxseed and mustard was applied over the abdomen, moistened with an infusion of hops. Cold applications were made to the head. At 9 P. M., pulse 130, temperature 104° . A mustard bath was given and iced brandy ordered to be given alternately with the powders.

At 6 A. M., the 15th, the bowels were easier, but the patient had vomited three or four times; pulse 120, temperature 102° . Treatment continued. At 1 P. M. resting at ease. At 7 P. M. pulse 115, temperature 101° ; the bowels had moved three times since my last visit; patient had vomited once.

At 8 A. M. July 16th, still improving. Case discharged.

CASE III.—Z. E., aged sixteen months. I visited him on July 17th, and learned from the parents that previous to my call he had had simple diarrhœa for a week or more. At time of visit the vomiting was persistent, the bowels acting at short intervals; stools very watery and in considerable quantity at each passage; pulse 130, temperature 104° ; patient very restless. During this visit the patient was seized with a convulsion, which lasted for about twenty minutes. The mustard bath was given, and the following prescribed: *R.* Potas. brom., \mathfrak{z} ij; aquæ menth. pip., \mathfrak{z} ss; aquæ distil., \mathfrak{z} jss. Mix. A teaspoonful every twenty minutes until quiet is restored. A poultice of mustard and flaxseed was applied over the whole abdomen, and as soon as he became quiet

the following prescription was given: *R.* Bismuth. subnit., pepsin sacch., $\mathfrak{a}\mathfrak{a}$ gr. xij, in ice-water, to be repeated every two hours. Cold applications to the head were also ordered. At 5 P. M. the patient was easy; pulse 120, temperature 102° . Bath again given and treatment continued.

I saw him again at 7 A. M. the 18th. He had vomited some three or four times, and the bowels had moved four times; pulse 115, temperature 101° ; treatment continued. At 1 P. M. bowels were acting more frequently and the vomiting continued. The bath was again resorted to and the following was prescribed: *R.* Bismuth. subnit., pepsin sacch., $\mathfrak{a}\mathfrak{a}$ gr. xij; pulv. Dover., gr. ss. Mix. To be given in ice-water every two hours; also iced gum water alternately. At 8 P. M. the patient was resting well; he had vomited twice, and the bowels had acted three times; pulse 115, temperature $101\frac{1}{2}^{\circ}$. Treatment continued.

At 7 A. M., July 19th, I found that his bowels had moved but three times during the night, and that he had vomited once; pulse 110, temperature 100° ; treatment continued. Saw him at 5 P. M.; he was still improving, and I discharged the case.

CASE IV.—On August 13th, at 2 o'clock A. M., I was called in haste to see H. R., aged fifteen months. I found him in a violent convulsion, which lasted about thirty minutes; bowels acting very freely, and there was much vomiting. I gave chloroform by inhalation, and had a large mustard poultice applied over the bowels, with smaller ones around the wrists and ankles. The convulsion being under control, he was put upon the following: *R.* Potass. brom., \mathfrak{z} ij; aquæ meth. pip., \mathfrak{z} ss; aquæ distil., \mathfrak{z} jss. Mix. A teaspoonful in ice-water every thirty minutes until patient

becomes quiet. The bismuth and pepsin, as prescribed in the other cases, were given every hour or two in ice-water. Cold applications to the head were also made. At 8 A. M. there was some vomiting, but the bowels were easier. The potass. bromide mixture was ordered to be given every two or three hours with iced gum-water and brandy, and pepsin and bismuth every hour or two. At 1 P. M. the patient was easy; treatment continued. At 8 P. M. had vomited but twice since my last visit; his bowels had acted four times.

7 A. M., August 14th, he had rested well during night; treatment continued. 5 P. M., patient still improving. I ordered the medicine to be given at longer intervals, and on the next day discharged the case.

OBSTETRICS.

Obstetric Surgery in 1880.

Dr. HARRIS (*Am. Jour. Med. Science*), April, 1882, reports five Caesarean sections in the United States during the year 1880. Sixty per cent. of the mothers and eighty per cent. of the children were saved.

During the same year there were then Porro operations in this country, which resulted in saving one mother and two children, the third child being a six months' foetus. During the same year Italy saved four Porro cases out of eleven; Germany, two out of five; Austria, three out of three; and France, one out of two. The above figures do not, however, correctly represent the value of the Porro operation, which indeed has not yet been fully determined. As a hospital measure it is much less fatal than Caesarean section. Thus the Santa Caterina of Milan has saved six women out of eight, and at the Vienna

Hospital eight out of eleven Porro cases have recovered. All the foetuses were removed alive.

Experience proves the value of uterine sutures and plenty of them in the Caesarean operation. Virgin silver wire is recommended and pure undyed and carbolized silk is regarded as a still better material for this purpose.

The lessons taught by Listerism have done much for both operations. J.

Temperature in Childbed.

Dr. NAPIER gives the following conclusions on this subject in the *Edinburgh Medical Journal*.

1. The average temperature for a few days preceding parturition is 98.5° to 99° : the subsequent heat is modified by the hour of delivery, but to only a small extent. The healthy puerperal range is 2.5° .

2. No temperature over 99° (unless accounted for by individual nervous susceptibility) is normal after four days. The healthy patient may have an *occasional* night temperature of 100° or 101° within the first four or five days, but a continuing, or even a morning or day record like this requires an explanation.

3. Slight causes, *e. g.*, constipation, retention of urine, etc., give a rise to 99° – 100.5° , sometimes more.

4. Retention of clots or secundines, 99° – 101° , or upwards; 103° at times.

5. Weid has a sudden late temperature of 103.5° , with a rapid pulse; the heat falls quickly with the development of the local affection. Other cases of mastitis are mildly febrile for several days.

6. Metritis (endo- and peri-) gives record of 103.5° , with slow pulse.

7. Peritonitis has a single rigor and a sudden early temperature of 104° or

upwards; the pulse is wiry. General peritonitis, if severe, 105.5° – 106° .

8. Pelvic cellulitis, oöphoritis, parametritis, etc., have a heat of 101° – 102.5° ; the pulse is weak and irritable. Recurrent rigors mark fresh deposits of pus, and are followed by temporary increased heat, 104.5° .

9. Pyæmia and uterine phlebitis average 103° , perhaps more. Cases in which the veins are rapidly affected are soon 104.5° to 106° , and end speedily. Pyæmia is frequently late in development, 7 to 10 days.

10. Septicæmia varies from 102.5° – 107° . The heat is never less, at least for some period of the twenty-four hours, than 102.5° , if the case is properly established. The temperature is liable to variations, but after the normal has been reached is less so than pyæmia. There is no security from remission till the night temperature is under 100° . Recovery may take place after 106° , but is rare.

11. Mental emotion may show 104° or even 106° , and we may sometimes have in addition symptoms resembling metro-peritonitis. These cases do not persist, and are generally normal in less than forty-eight hours.

12. If the temperature does not rise within ten days from delivery, there is little risk of grave disease, unless from gross imprudence in exposure to cold, or zymotic infection.

13. Although the temperature is moderately low, 100° – 101° , so long as the pulse continues 120° or more, we are not safe from relapse. No anxiety need be felt so long as the temperature is kept under 102° . However fast the pulse, if the temperature continues low the prognosis is favorable. An evident exception pertains when temperature is low from collapse. If the temperature is persistent at 102° , or frequently recurs

to this point, there must be an abnormal organic condition.

14. Temperature should be observed night and morning for the first seven days, and daily for three to seven days after, more especially if any instrumentation has been required for delivery, or if zymotic or epidemic disease prevails. When an abnormal temperature is discovered, it should be reduced to the normal as early as possible by one or other agent. It is of the highest moment to bring it down to 100° and keep it there or lower.

Prolonged Gestation.

Dr. L. A. RODENSTEIN (*N. Y. Med. Jour. and Obstet. Review*), reports four cases of "prolonged gestation."

From his own experience and the observations of others, he concludes that gestation may be prolonged at least for two months beyond term.

After the uterus, he says, has performed its physiological function of gestation for the natural term, it rests, but does not necessarily at once expel its contents.

The child, even though born at the eleventh month, is not of unusual size, having lain "dormant" during the extra two months of inter-uterine life.

We fear Dr. R.'s readers will prefer to believe with Prof. Lusk, that "gestation protracted beyond the two hundred and eighty-fifth day is of very rare occurrence."

Mistaken data are undoubtedly accountable for the doctor's supposed cases of prolonged pregnancy and his extraordinary conclusions therefrom. J.

Paget's Disease of the Nipple.

By Paget's Disease of the Nipple is understood a peculiar eczema-like affection of the nipple, which, though closely

resembling eczema, differs from it in its well-defined margin, in its intractability, and in that it invariably leads to cancer of the ducts in middle-aged persons, if allowed to continue for some months. The relations of this disease were first pointed out by Paget, and hence the name. Munro relates several cases of the disease. In one of them, notwithstanding the nipple was removed before any symptoms of cancerous disease had appeared the affection returned in the cicatrix, and was subsequently followed by cancer in the gland.—*Med. and Surg. Reporter.*

Cracked Nipples.

Le Paris Médical publishes a number of formulæ, which are recommended in this complaint: No. 1. \mathcal{R} . Cosmoline, \mathfrak{z} xiiss.; liquid balsam Peru, \mathfrak{z} i $\frac{1}{4}$. M. No. 2. \mathcal{R} . Oxide of zinc, \mathfrak{z} i $\frac{1}{4}$; cold cream of cosmoline, \mathfrak{z} x. M. No. 3. \mathcal{R} . Glycerole of starch, \mathfrak{z} viiss.; oil of cade, \mathfrak{M} xlv. M. No. 4. \mathcal{R} . Cacao butter, \mathfrak{z} iiss.; oil sweet almonds, \mathfrak{z} ss.; extract of rhatany, \mathfrak{M} xv. M. No. 5. \mathcal{R} . Gutta percha, \mathfrak{z} j.; pure chloroform q. s. to dissolve. By anointing the excoriations with this a slight film is formed, which will not become detached, even after sucking.—*Ibid.*

Sore Nipples.

Dr. FAVRE (*St. Petersburg Medicinische Wochenschrift*), claims that there are two varieties of these, fissures and erosions, and believes that the latter are to a large extent due to tight fitting dresses and pressure by corsets. He advises that the nipples be sprinkled with bismuth, dry, or that this be made into an ointment in the proportion of one of bismuth to two of vaseline. This procedure has often resulted in a cure within twenty-four hours.—*Chicago Med. Review.*

Sore Nipples.

This very disagreeable condition can be ameliorated and cured by using tincture of benzoin. They should be washed freely with the tincture, and will heal in five to ten days. The benzoin forms a varnish over the nipple and protects them during nursing and does not in any way interfere with lactation. Non-specific sores are the only ones benefited by this treatment.—*E. M. Jour., Cincinnati Obstet. Gazette.*

Retracted Nipples.

So soon after labor as the female has had a little repose, the child must be put to the breast, the effect of which is to remove a certain amount of the fluid from the milk ducts; and at the same time this is the most efficient method by which a retracted nipple is drawn out or elongated. Another effect is to act sympathetically upon the womb, producing contraction of that organ; it is in this way that nursing increases after-pains, and that it sometimes relieves a tendency to flooding. If the nipple is too short, or flat, for the child to take hold, it may be drawn out by the gentle suction of the breast-pump, or what is better, by filling an ordinary quart bottle with hot water, and allowing the liquid to remain until the bottle is well heated, after which it is poured off and the mouth of the bottle immediately placed against the breast, inclosing the nipple. The bottle is held steadily in this position until it cools, the latter process being aided, if desired, by wrapping its body with a cloth wrung out of cold water. The effect of the cooling is to condense the inclosed air, and create a partial vacuum within the bottle, thus causing the nipple to be firmly sucked up within its neck; when this state of things has been maintained

for some minutes, and the bottle is removed, the nipple will be found considerably elongated, and standing out prominently, in which condition the child is enabled to take it into its mouth and nurse. This procedure may have to be repeated a number of times on each breast, until the nipples assume a more permanent shape, and the child gains greater confidence and experience.

The advantage of this bottle arrangement is that it acts steadily and gently. It is most important to bear in mind that *gentleness* and *steadiness* should characterize all efforts made either with a view of drawing out the nipple, or of emptying the breasts.—*St. Louis Cour. Med.*

Atresia of Large Intestines.

Dr. CHAMBERS recently reported to the Clinical Society of Maryland a case of complete atresia of the large intestine involving the rectum and the colon below the splenic flexure. The infant died on the second day after birth.

Artificial Anus and Death Resulting from Faulty Ligation of Umbilical Cord.

The Maryland *Med. Journal* reports a case of artificial anus occasioned by tying a knuckle of intestine with the umbilical cord. The ligature was applied by an irregular practitioner too close to the body. Death followed on the sixth day.

Puerperal Eclampsia.

Dr. THEODORE TRUMBULL (Chicago *Med. Jour. and Ex.*) reports a case of puerperal eclampsia in which, failing to observe any decided effect from chloroform (Squibb's), he found the following effective in warding off a second attack: \mathcal{R} . Chloral hydrat, gr. cccxx.; 21.33 gm.; potassii bromid, \mathfrak{z} j.; 30.90 gm.; tr. opii deodorat, fl. \mathfrak{z} iv.; 16.00 fl.gm.;

aquæ, fl. \mathfrak{z} iijss; 105.00 fl.gm. M. Sig. A dessertspoonful in a tablespoonful of water every three hours.

Dr. J. B. TODD, of Parish, N. Y. (*Med. Annals*), relates two cases of puerperal eclampsia controlled by hypodermic use of half-grain doses of morphia sulphas. He thinks the large doses of Dr. C. C. P. Clark uncalled for, and deems it better practice to administer the drug in smaller doses.

Tying the Cord.

Dr. W. T. LUSK (*Amer. Jour. Obstet.*):

1. The cord should not be tied until the child has breathed vigorously a few times. When there is no occasion for haste, growing out of the condition of the mother, it is safer to wait until the pulsations of the cord have ceased altogether.

2. Late ligation is not dangerous to the child. From the excess of blood contained in the fetal portion of the placenta, the child receives into its system only the amount requisite to supply the needs created by the opening up of the pulmonary circulation.

3. Until further observations have been made, the practice of employing uterine expression previous to tying the cord, is questionable.

4. In children born pale and anemic, suffering at birth from syncope, late ligation furnishes an invaluable means of restoring the equilibrium of the fetal circulation.—*Pac. Med. and Surg. Journal*.

Prevention of Laceration of Perineum.

Dr. G. HURD, of St. Louis, Mo., holds that a sharply flexed and abducted condition of the thighs jeopardizes the safety of the perineum, during the passage of the child's head, and relates

cases (St. Louis *Med. and Surg. Journal*) in which rupture was apparently averted by extension of the mother's leg at the moment of perineal distension by the child's head.—*Chic. Med. Review*.

Sign of Pregnancy.

Dr. DELATTRE mentions, in the *Gaz. des Hôpitaux*, what he considers a constant sign of the beginning of pregnancy, namely, the almost complete disappearance of the phosphates from the urine. The author believes that they are condensed into the bones of the mother, forming osteophytes, during the first months of intra-uterine life. During the last months, the foetus developing rapidly, this reserve of phosphates is drawn upon, the bones of the child increase in weight, and the osteophytes gradually diminish, until they finally disappear, usually after the first month of nursing. Where the mother is weakly, instead of having these reserves, she is compelled to borrow from her proper substance the necessary elements for the nutrition of the foetus, and her strength becomes exhausted. In such cases the author recommends the use of phosphate of lime during the whole course of the pregnancy.—*Med. and Surg. Reporter*.

Galactagogue.

H. B. PERCT (*Therap. Gazette*) thinks he finds in fluid extract of jaborandi valuable galactagogue properties. He administers the drug in doses of ten to fifteen drops.

On the Treatment of Puerperal Mania.

Dr. C. P. LEE (*Kansas Med. Index*): In these cases I have derived much benefit from the entire exclusion of the solar light from the patient's chamber,

enjoining quietness, and avoiding all unnecessary interrogation. A light, nourishing diet; the tepid bath once every day. But a little additional treatment is all that I regard as essential in the treatment of puerperal mania when no bodily disease exists.—*Med. and Surg. Reporter*.

Vomiting in Pregnancy.

The following formula is recommended by Prof. GOODELL:

R. Cerii oxalat.; ipecachuanhæ aa., gr. i.; creasoti, gr. ij. m.s.

S. Take every hour until relief is obtained.—*Southern Practitioner*.

Use of Forceps.

In an extended discussion on the use of the forceps in the Obstetrical Society of London, Dr. BARNES formulated his belief as follows:

(1) In lingering labor, where the head is in the pelvic cavity, the forceps is better than its alternatives (ergot, version, craniotomy). (2) In lingering labor, when the head is engaged in the pelvic brim and when it is known that the pelvis is well formed, the forceps is better than its alternatives. (3) In lingering labor, when the head is resting on the pelvic brim, the liquor amnii discharged, and it is known either by exploring with the hand or by other means, that there is no malposition, or only a slight degree of disposition, even though the cervix uteri be not fully dilated, the forceps will generally be better than its alternatives. (4) In proportion as the head is arrested high in the pelvis, in the brim or above the brim, the necessity, the utility and safety of the forceps become less frequent.—*Pac. Med. & Surg. Jour.*

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

The Ovary and its Seat.

M. FÉRÉ has lately settled affirmatively the long mooted question as to the true seat of ovarian pain; showing by a series of experiments that it is in the ovary. Profiting by the physiological ascent of the ovary during pregnancy, he discovered that the painful spots ascended parallel to the ovaries.

A more important verification was made during the uterine contractions of labor. On the left side where the ovary is more accessible on account of the rotation of the uterus, a small ovoid tumor, as large as the end of the thumb, was found, movable and gliding on the resisting surface of the contracted uterus. Pressure on this little tumor produced the ordinary phenomena of pressure on the painful ovarian point. During the entire duration of labor and subinvolution of the uterus, the ovarian points gradually descended, and only become stationary when the uterus attained its normal dimensions, and the ovary its habitual situation.

It has been still further demonstrated, pathologically, by M. Baraduc. In a patient, very neuropathic and suffering from retroflexion so pronounced that the finger introduced into the vagina, could feel the two ovaries above the lateral cul-de-sac, pressure exercised by the intra-vaginal finger on the ovary produced pain clearly ovarian. After reduction of the retroflexion, pressure at this place produced no pain, the ovaries having regained their normal position.—*Revue Méd. Franc. et Etrang.—N. C. Med. Jour.*

Two Cases of Unilateral Vaginal Oöphorectomy.

In a paper read before the London Obstetrical Society, Dr. Braithwaite reports two cases of vaginal oöphorectomy. The first patient, a woman aged thirty years, suffered from attacks of dyspnœa on slightest exertion, from which certain positions of the body relieved her.

Her general health was bad, and there was a mitral murmur and feeble breast-action. The dyspnœa was supposed to be cardiac, but connected in some way with a prolapsed ovary, pressure upon which caused excessive pain, but no dyspnœa. After removal of the prolapsed ovary, the dyspnœa was greatly relieved but not entirely cured.

In case II, the patient, a woman aged twenty-three years, suffered constant pain in the left ovarian region since the birth of her first child, three and a half years ago. The left ovary was prolapsed and very tender. Its removal resulted in a complete cure.

The author thought the vaginal method of oöphorectomy, for removal of prolapsed and non-adherent ovaries the best.

Dr. Robert Barnes relates a case in which he had removed the ovaries, and a fibroid tumor, which was the cause of the suffering, had almost shrunk away.

Dr. Hielsinbotham supposed there might have been hysteria in Dr. Barnes' first case, from which she was relieved by the therapeutic measures and rest incident to the treatment.

Dr. Heywood said the interest in the

case would be greatly increased, if the patient's condition a year or so hence was reported; for Dr. Batty found that where only one ovary was removed pain was likely to recur in the other. He held the abdominal operation to be the preferable one in single women.

Dr. Knowsley Thornton said that accumulated statistics showed the abdominal method to be the safest operation.

Dr. Greves stated that in all his cases in which he had performed it for local suffering, he had had excellent results.

The President thought the removal of one ovary for treatment of cardiac dyspnea a wild proceeding.

Dr. Braithwaite thought there was no hysteria in either case. He had heard since sending in the paper, that the first patient was suffering from cardiac dropsy, and supposed, if the operation had been performed earlier, results would have been better.—*British Med. Jour.*

Is the Ovarian Cell Pathognomonic?

The accurate diagnosis of ovarian tumor is of vital importance, as mistakes are by no means rare, even among our most skilful diagnosticians. In the *American Journal of the Medical Sciences*, for April, Dr. W. A. Edwards published an account of some researches made in the Pathological Laboratory of the University of Pennsylvania, bearing on the value of the ovarian cell as a diagnostic point, from which he concludes:

1. The ovarian cell is not diagnostic of the ovarian tumor.
2. We may have a fluid from an ovarian tumor entirely devoid of the ovarian cell.
3. On the other hand, we may have an abdominal fluid which is not ovarian, presenting the cell in great abundance.
4. With the present state of our

knowledge, the accurate microscopical diagnosis of ovarian dropsy is impossible; the most distinguished ovariotomists always make their first incision an exploratory one.—*Ohio Med. Jour.*

[Considerable attention has been given to this subject of late, and we wait with great interest to hear Dr. Drysdale's Paper on the Ovarian Cell, which he is to read at the next meeting of the American Gynecological Society, in September.]

A. J. C. S.

Vesical Disorders of Women.

N. V. SPEECE, M. D., Quincy, O. (A paper read before the Logan County Medical Society, and published in the *Ohio Medical Journal*.) In this paper, of five pages, the author discusses the importance and prevalence of diseases of the urinary organs in women, the causes, diagnosis and treatment of vesicle disorders, and the treatment of a number of diseases which causes irritation of the bladder. The whole concludes with a dissertation on the fashionable follies of the age.

The original portions of this very brief but exceedingly comprehensive paper are the following:

"Where great tenderness of the walls of the bladder is found, the following mixture will be found to exert a beneficial influence: \mathcal{R} . Tr. iodinii; fl. ext. belladon., āā $\frac{3}{4}$ ss. M.—Paint this mixture on and over the points of tenderness two or three times a day.

"Where fissures of the rectum or hemorrhoids are found, active measures are to be instituted by cauterizing the fissure with a solution of nitrate of silver, forty grains to the ounce of water, or painting with a mixture of chloroform and glycerine. A few applications of this character will soon effect a cure of the fissure."

Suppuration in Ovarian Cysts.

Prof. M. J. HOROWITZ, the author, speaks of the etiology and symptoms of suppurating ovarian cysts, and, on grounds of his own observation, argues for operative interference as soon as symptoms of suppuration show themselves. In a few cases in which puncture was thought sufficient, the author saw death from septicemia follow.

Olhausen's theory that the passage of matter from the bowels causes the suppuration, did not hold in his cases, as there were no adhesions to the bowel present.

Spontaneous inflammation might, however, be set up by an occasional larger exudation into the cyst, causing pressure with maceration and irritation of the cyst wall.

Prof. Horowitz believes in a chronic inflammation with occasional exacerbations. The fever is not high and of a remittent character. Parts of the tumor, and especially the epigastrium, show increased sensibility. The pulse is feeble and its frequency not in proportion to the rise of the temperature.

In the differential diagnosis between suppuration of an ovarian cyst and circumscribed peritonitis, the author states the following points :

Circumscribed Peritonitis.

1. Continued fever with slight remissions and high temperature. In chronic peritonitis intermittent fever.
2. Frequent chills.
3. Pulse feeble and frequent, depending on temperature.
4. Pain, depending on degree of inflammation and confined to the part or parts.
5. Short duration.
6. Increased resistance of the swelling.
7. Frequent tendency to emesis.
8. The general condition, account of shorter duration of the disease, better.

Suppuration of an Ovarian Cyst.

1. Remittent fever, with strong remissions in the beginning. High temperature rare.
2. Occasional chills, not so strong and of shorter duration.
3. Pulse feeble, not so frequent, and not depending on temperature.
4. Pain not so severe, localized in the epigastrium.
5. Longer duration.
6. Resistance not increased.
7. Tendency to emesis rare, and in later stages only.
8. Emaciation rapid.

Some cases of suppurative ovarian cyst are complicated by peritonitis, thus greatly increasing the difficulty of a correct diagnosis. The puncture of the cyst and microscopical examination of the contents is of the greatest importance for a positive diagnosis.

The only treatment offering any chance of recovery is extirpation of the cyst.
—*Deutsche Medizinical Zeit.—Obstet. Gazette.*

Iodoform in Ovariectomy.

Dr. LEOSCHIN, in four cases of ovariectomy sprinkled the stump and stem twice with powdered iodoform. The first time after cutting loose the cysts, and the second after the operation had been completed.

He also used it upon all parts of the peritoneum touched by the fingers or his instruments, in the ends of the ligatures, and also on the external wound, which he then covered by Lister's gauze dressing and a disinfected sponge.

Three of these cases, one of which was a suppurating cyst that tore during the operation, recovered without reaction or fever.

In the fourth patient, parametritis set up, and was still under treatment at the time of publication, the thirty-second day after the operation.—*Deutsche Medizinische Zeitung*.—*Ibid*.

An Ovarian Tumor with Rare Complications.

Dr. A. P. DUDLEY and Dr. H. C. COE, of the house staff of the Woman's Hospital, in a joint communication published in the *New York Medical Journal and Obstetrical Review*, for July, 1882, remark that it is a well recognized fact that statistics of ovariectomy are among the least satisfactory of any in surgery. For a man to report that he has had so many "successful cases" may mean simply that he has the good luck to secure a run of uncomplicated ones, such as would have recovered under the hands of any other operator. The public are too prone to judge of success by the outward results alone, overlooking the skill, judgment, boldness in meeting emergencies, and the care and anxiety in after-treatment, which a surgeon has bestowed upon a desperate case, and in spite of which it has terminated fatally.

To judge of an ovariectomist by the bare statement of the number of his patients who have survived the operation would be most unjust. So varied are the elements which enter into every case of ovariectomy, and which render it complete in itself, that it is quite impossible to institute close comparisons, either between individual cases or between the statistics of two different operators. They then give the history of a case that occurred recently in Dr. Thomas' service at the hospital. The patient had a severe illness at the age of sixteen—an acute intestinal trouble of some sort. After that she was always obstinately constipated, and occasionally had severe colic, with vomiting and tympanites, and was said to have passed gall stones on several occasions. When she entered the hospital she had been married twenty years, but had had no children, and for ten years she had not menstruated. Eighteen months before her admission her health began to fail, and she noticed a slight enlargement of the abdomen, attended with severe pains localized on the left side. Soon after this she passed several concretions by the urethra, and began to discharge fecal matter and gas by the same channel. The tumor grew slowly, confined almost wholly to the left side, and attended with constant intense pain and marked gastric disturbance. It was tapped shortly before her admission, but no fluid was obtained. Dr. Thomas regarded it as uncertain whether the tumor was an ovarian cystoma or a uterine fibrocyst, but felt that its removal would be quite impossible on account of its complete fixity and firm adhesion to all surrounding parts. He made an incision four inches in length to the left of the median line, this being the most prominent part of the tumor, thus dividing the abdominal muscles. The sac, which

was found to be firmly adherent on all sides, was punctured, and a quantity of dark-brownish, colloid material evacuated, with the patient turned upon the side. The external incision was extended to five inches; the cyst opening was also enlarged, and the operator introduced his hand and broke up a number of secondary cysts, removing their contents. The cyst was found firmly adherent to the intestines and pelvic visera. Accordingly, the edges of the cyst-opening were stitched into the edges of the wound, a Thomas' double drainage-tube being introduced into the sac, brought out at the lower angle of the incision, and held in position by interrupted wire sutures. The patient died on the eighth day. At the autopsy the visceral and parietal layers of the peritonæum were found so firmly united by old adhesions that it was with difficulty that the cavity could be opened at all. The liver was adherent to the diaphragm, anterior abdominal wall, stomach, duodenum, and transverse colon. The spleen was surrounded by old adhesions. The coils of small intestine were adherent to the abdominal parietes, and so firmly glued together that they formed an inextricable mass. The intestines were also adherent to the posterior wall of the bladder, the superior and posterior aspects of the uterus, and to the surface of tumor. Douglas' fossa was entirely obliterated. Upon separating the adhesions near the fundus of the bladder, a cavity of about the size of a hen's egg (diameter four centimeters) was found, which seemed to be a portion of the general peritoneal cavity, shut off by adhesions. It was bounded in front by the posterior surface of the bladder, at its upper third, latterly and posteriorly, by the mass of adherent intestines. This cavity communicated both with the small intestine and with the bladder, in

the former case, by two fistulous openings about six mm. in diameter, situated close together, and each leading into a separate knuckle of small intestine. As nearly as could be ascertained, one communication was with the ileum, the other with the jejunum. There were three openings from this false cavity into the bladder, situated side by side, and separated only by narrow bridges of tissue; the largest measured one centimetre in diameter, the others two and three mm., respectively. The bladder was thus opened through its posterior wall, near the fundus. The cavity above described contained a mass of soft, yellowish fæcal matter, and three hard, black calculi of irregular shape—all too large to have passed, fully formed, through the fistulous openings in the intestines. (Analysis of these calculi showed them to be enteroliths.) The pelves and calyces of the kidneys were much dilated, the renal parenchyma being atrophied and the seat of a chronic diffuse nephritis. No evidence of an acute interstitial nephritis. The dilated pelves contained a dirty, brownish, purulent fluid, having an offensive urinous odor. Both ureters were greatly dilated, the dilatation extending along their whole course, the caliber of the right being nearly equal to that of the small intestine. They contained an offensive fluid similar to that in the pelves. The bladder was capacious, its longest diameter being eleven ctm. It contained soft fæcal matter, turbid urine, and gas. The uterus was normal. On the right side the adnexa were completely buried in a mass of adhesions. Upon the left side the site of the ovary was occupied by a polycystic tumor, which filled the pelvic cavity and extended upward into the abdomen. Its diameter was four ctm. It was adherent to the small intestines and to the sigmoid flexure, which lay

behind it. The upper half of the tumor had a peritoneal covering, while the lower half was devoid of it. The growth was found to be a multilocular ovarian cyst, having one large cavity, the inner wall of which was covered with papillomatous growths. This inner surface was of a black color, and in places was sloughing.—*Det. Clinic.*

Perforation of the Bladder by the Dermoid Cysts of the Ovary.

WÆLLE (*Centralblatt für Gynakol.*) reports a case of perforation of the bladder by a dermoid ovarian cyst. The patient had suffered for five years from dysuria, hematuria and gravel. Upon examination, a tooth was found in the bladder. The patient eventually died with symptoms of acute peritonitis. At the autopsy a dermoid cyst, containing a tooth, was found adherent to the posterior wall of the bladder, there being a communication between the two cavities.—*Obstet. Gazette.*

Total Extirpation of the Uterus through the Vagina.

CHRISTIAN FENGER, M.D., of Chicago (*Amer. Jour. of Med. Sciences*): The case was one of mixed cylindrical and multiform celled carcinoma of the cervix and lower half of the fundus of the uterus, of over eight months' standing, in a woman of forty years of age. There was enlargement of the fundus, but no tangible infiltration of the broad ligaments, bladder, rectum or vagina; total extirpation was accomplished through the vagina, with complete recovery from the operation.

Malignant growths of the uterus have thus far been the only indications for the vaginal extirpation of that organ. Comparing the statistics of the abdominal with those of the vaginal operation,

it is safe to say that whenever the total removal of the organ is indicated, and this can be done through the vagina, the latter method is shown by Dr. Fenger to be preferable to the operation by abdominal section.

As regards the control of hemorrhage from the broad ligament in total extirpation, Fenger agrees with Billroth, Mikulicz and Schroeder, that the ligature *en masse* is the safest and the most easily accomplished. His method of treating the peritoneal wound is in accord with Czerny and Martin, as opposed to the practice of Billroth, Mickulicz and Schroeder, in that he closes the wound throughout its entire extent as carefully as possible, while he lays great stress on the value of permanent irrigation as contrasted with drainage-tubes, particularly when the bladder or rectum has been opened. He also describes a modified form of Mikulicz's irrigator, which offers considerable advantages.

Removal of the Entire Uterus for Cancer of the Cervix.

In the *American Journal of the Medical Sciences*, Dr. CLINTON CUSHING reports two cases of removal of the uterus for the cure of cancer of the cervix, one of which was successful and one was fatal, with the following deductions:

First. Do not undertake the operation of entire removal of the uterus if the surrounding tissues are involved in the disease, or the uterus is at all fixed, for the operation is then very difficult, and the disease would certainly return at the seat of operation.

Second. Operate by the vaginal method, it being a much safer one.

Third. Leave the opening made by the removal of the uterus open, so as to allow perfect drainage, there being apparently no disposition to prolapse of the small intestine.

Fourth. Keep a self-retaining catheter in the bladder, in order to avoid its distension, and to prevent the too frequent disturbance of the patient.

Dr. Cushing suggests that, where it can be done, enough of the diseased structure be removed for a microscopical examination before the decision is made final as to the advisability of an operation.—*Med. Gazette.*

Nitrate of Lead in Cancer of the Cervix Uteri.

M. CHERON, in the *Revue des Maladies des Femmes*, says that he has had very good results from the direct application of the nitrate, powdered, to the ulcerated cervix. After touching the ulcerated surface with glycerine, he injects about a quart of cold water, containing about a drachm and a half of tr. ferri perchlorid., and then dries the surface with absorbent cotton. Finally, the following powder is introduced, by means of a syringe made for injecting powders:

R. Plumbi nitrat., pulv., $\frac{3}{4}$ ss.; Lycopod., pulv., $\frac{3}{4}$ j. M.

The powder is retained in place by a tampon of cotton. Through this means suppuration diminishes considerably, as also the bad odor. Even hemorrhage is not so profuse, and in some cases it is entirely suppressed.—*Med. and Surg. Reporter.*

DISEASES OF CHILDREN.

Cool Air, etc., in Measles and Scarlet Fever.

Dr. THOMAS N. REYNOLDS (*Det. Clinic*). Many children die or recuperate badly in measles and scarlet fever from want of fresh air. The same obtains in other affections also, but proportionately perhaps oftener in these two or the major exanthemata.

The people imagine heat indispensable and they dread draughts. Physicians

advise a warm atmosphere sometimes to favor eruption on the surface, to protect the air passages in measles and the kidneys in scarlet fever, and the result is often bad air for respiration. Equable heat to the body is necessary, but should be maintained by the clothing or artificially in the bed and not by raising too high the temperature of the room. Better have it rather low than too high, provided the body be kept warm.

Hot air is not generally necessary for the bronchial affection in measles. I have seen a case do well in a room that froze water at night, and have come to think lately that a somewhat cool room is best always in measles and scarlet fever, whether sthenic or asthenic. Not over 60° Fahrenheit in winter is better, and as cool as possible in summer, with very free ventilation.

In scarlet fever especially cool fresh air is essential to promote active interchange of the normal gases in the lungs and elimination through them also of some of the poison. It relieves restlessness and is sedative because grateful to the patient. It is antipyretic somewhat from mere presence in the nares and throat; and nothing is so decided a vasomotor stimulus as cool, fresh air when supplied for respiration in place of the hot and impure. It gives firmness and efficiency to the whole circulatory apparatus.

Efficient capillary and venous circulation favors secretion and excretion and relieves internal congestions; in scarlet fever necessary in the glomerular and intertubular capillaries of the kidneys, and the automatic nervous ganglia of both body and brain.

In both these affections the stomach and bowels should have attention at first; patients are usually taken in full habit, the temperature rises, the secretions are checked, and the bowels should be

moved at once. Sometimes they have moved sufficiently, but generally not. Solid food should then be withheld till the eruption is over. Little more than small drinks of water should be given in sthenic cases for the first two or three days.

Medicines are rarely necessary in ordinary uncomplicated measles except to please friends.

In scarlet fever where the temperature is greater I give vegetable acids diluted with water freely for the first few days, or whenever there is thirst, and as long as they agree with the stomach and bowels. Citric acid is good in the form of lemonade without sugar. I prescribe for a child four or five years old: \mathcal{R} Acidi acetici diluti, \mathfrak{z} ss; Aquæ ad., \mathfrak{z} iv.; Misce et fiat Mistura. Sig.—Teaspoonful in water every hour if awake.

It proves in a degree diuretic, diaphoretic, antipyretic and sedative, and promotes elimination from the alimentary mucous surface. It increases destructive metamorphosis, especially adipose, so desirable in the fleshy. This, with its stimulus to elimination, tends to lower heat of body; and renders it to a certain extent curative as well as an agreeable drink. It is a sedative largely from allaying the thirst.

Mineral acids do none of those things so well and are not so appropriate during the stage of eruption.

Digitalis is beneficial in venous distension and weak cardiac contraction.

Quinine is essential in malarial complications, and generally useful in high temperature and extreme septicæmia, but need not be resorted to at first, and rarely at all in scarlet fever.

The cold bath is not generally without some risk from shock or imperfect reaction; but extreme temperature may be lowered somewhat by cold to the head and palms of the hands and occa-

sional quick sponging of body with cold water, followed by friction.

We close with the end of the eruptive stage; for the acute tubal nephritis, median otitis and lymphadenitis, if they happen to follow, form new considerations, and are the principal results, besides death, we try to prevent.

Infectivity of Scarlatina.

Dr. ALFRED CARPENTER read a paper before the society of medical officers of health on some of the causes which increased or modified the infectivity of scarlatina. He considered that a long period of quarantine—such as eight or ten weeks, and sometimes four months—was to be deprecated in the case of children recovering from scarlatina; he himself, for many years, had isolated cases for a fortnight, and in some instances for a week only, after the departure of the fever, and he had never heard of any evil result accruing from such a course. He next mentioned various cases in large schools, which served to explain his views as to the causes of scarlatina. The first outbreak of which Dr. Carpenter made mention was, in his opinion, entirely caused by a cesspool situated in the school yard, which was the recipient of washings from a slaughter-house; and once a week at least, the aerial contents of this cesspool were displaced into the closets of the boys, situated in close proximity to it. As soon as this cesspool was emptied, and the drains properly directed into the sewer, scarlatina ceased to appear in the school. Want of proper ventilation in the soil-pipe and drains belonging to the building, caused an outbreak of scarlatina in another school—the drains being in direct communication with the main sewer of the district, and scarlatina being also at that time very preva-

lent in the neighborhood. Dr. Carpenter believed that the nature of the blood into which the poison was received aided more materially in increasing the mortality from scarlatina than the character of the poison itself; and in support of this theory, he instanced two outbreaks of this disease, in one of which the mortality had been excessive, fourteen persons having died out of seventy-five who were attacked; and, in the other outbreak, only three deaths occurred, though the total number of cases was one hundred and eight. Dr. Carpenter attributed this difference in the mortality to the surroundings of the children; in the one instance the conditions were on the whole healthy, while in the other the children were exposed for a much longer period to an impure atmosphere, and were badly cared for at home. The cause of the two outbreaks was similar in character; the excreta of the first case of scarlatina in each school, passed down unventilated drains, which communicated directly either with class-rooms inhabited by the children, or with closets used by them. In conclusion, Dr. Carpenter said that he believed scarlatina more often arose from sewage-emanations, or from sewage contaminated with scarlatina germs, than from personal contact. He considered that in many cases where the cause of the disease had not been discovered, it might have been found, on careful investigation, to proceed from some accidental inhalation of sewer air; and that persons who were constantly exposed to such an atmosphere were liable to more severe attacks of scarlatina and diphtheria than those who inhaled the poison for a short season only. Dr. Carpenter also suggested that the discharge of hot water and waste from steam engines into the sewers, was a source of danger in producing scarla-

tina and diphtheria. — *British Med. Jour.*

Incontinence of Urine in Children.

The combination of ergot, belladonna and iodide of iron is used at Bellevue Hospital and proves more useful for incontinence of urine in children than either of the drugs alone or in any other combination which has been tried. — *Med. Record.*

Case of Croup Treated by Passing Catheters into the Trachea by the Mouth.

J. WILSON PATON, M. D., M.R.C.S. (*British Medical Journal*): H. J., aged three years and ten months, had measles, the rash appearing on February 15. On the disappearance of the rash a hard cough supervened, which gradually increased in severity until March 1. On that date I found him at 1.30 A. M. suffering from intense dyspnea, quite unable to speak, and his lips of a dark livid color. His cough was constant, brassy, and without expectoration. The respirations were 35 per minute, the cartilages of the ribs and sternum being drawn in at every effort to breathe, and crepitation existing over both lungs. The fauces were healthy. The pulse was 144, very weak. Having a No. 11 prostatic catheter with me, I determined to pass it into the trachea, instead of performing tracheotomy. Watching an opportunity, while the tongue was depressed with a spoon, the catheter, curved a little more than usual, was passed into the trachea during an attempted inspiration and without the slightest difficulty. A severe struggle followed, lasting perhaps a minute or two, the face becoming purple and the eyes staring with fully dilated pupils. The paroxysmal efforts to expel the tube being unsuccessful, a pretty full inspiration, partly through the tube and

partly through the larynx, followed; about two ounces of frothy, bloody and purulent mucus were ejected by the tube and the mouth, the livid color disappeared, and he lay down, breathing easily through the tube. The presence of the tube did not prevent his swallowing milk, though sometimes a little of this was ejected during a cough. The tube was retained *in situ* by a strip of plaster, and the teeth were prevented from closing on it by means of a pear-shaped piece of hard wood. Six hours afterward he was much easier, and could say "Yes" and "No" distinctly. The cough continued at intervals of ten minutes, and did not seem altered in character by the presence of the tube. Crepitation still existed over both lungs, an abundant muco-purulent secretion passing both by the tube and the mouth. Hitherto he had been kept in a warm room, but now a bronchitis-kettle maintained a moist temperature of 70° F. The tube was removed without any inconvenience after it had been in the trachea for eleven hours, as he had bitten it, and no air was passing through it. Shortly after its removal symptoms of obstruction gradually reappeared. During the same evening another ordinary gum-elastic catheter No. 12 was introduced, a slight momentary struggle and cough supervening. The presence of the tube led again to a very free expectoration of mucus. In the course of a few hours the respirations and pulse became lower, and crepitation and dyspnoea ceased. When the tube had been in forty-eight hours and a half it was removed and not again introduced. On March 8 the voice and chest sounds were normal, and he was not seen after the 10th. The case was a severe one, and would have soon ended fatally had no operation been performed. Tracheotomy seemed inadmissible, neither

the case nor the surroundings being favorable for it. *Prima facie*, it would be expected that the introduction of a tube into the trachea of a child against its will would not be so easy as in a consenting adult. That may be so; but it is certain that the operation is extremely easy and simple, and does not take more than two or three seconds from touching the tongue with the spoon till the tube is in the trachea. Had tracheotomy been performed successfully, when would the child have been out of danger? Certainly not so soon as here recorded; for at the end of the third day the child was so well as to be able to breathe freely without the tube, and was quite well before the tenth day after the operation.—*Can. Med. Record.*

The Action of Calomel on Fermentation and on the Life of Micro-Organism.

A paper with this heading appears in the last number of Hoppe-Seyler's *Zeitschrift für Physiologische Chemie*, by N. P. Wassilieff, who, after noting the high estimation in which calomel has been always held in disordered conditions of the bowels, especially in children, points out the absence of any experiments to show or explain the cause of its influence, with one or two exceptions. Voit, indeed, as long ago as 1837, observed that albumen and blood mingled with calomel were capable of being kept for days without any indication of putrefaction, and Hoppe-Seyler made some similar observations; but besides these, few, if any, researches have been made on its action. In M. Wassilieff's experiments, calomel was added to the fluid obtained by acting on albumen with pancreatic juice; and he satisfied himself that the albumen-digesting ferment of both these fluids was not damaged by calomel—peptones

in the one instance and leucin and tyrosin in the other, appearing as usual—but that the presence of this substance prevented the formation of the secondary products, such as indol and phenol. Neither hydrogen nor hydrogen sulphide formed in the fluids containing calomel, whilst they were abundantly produced in the others. In like manner the author experimented on the effect of calomel on the fat-digesting and the amylolytic ferments of the pancreas, and found that it had no modifying influence upon them, but that it arrested the changes which followed their completion, entirely preventing, for example, the butyric acid fermentation and putrefactive processes. He hence arrives at the conclusion that calomel acts different on the formed or organized and the unformed or unorganized ferments, permitting the action of the former to proceed unchecked, but completely preventing the action of the latter.—*Cincin. Lancet and Clinic.*

Ophthalmia Neanotorum.

Few infantile diseases are more troublesome and annoying than purulent ophthalmia in the new-born. It is generally attributed to direct inoculation with the maternal discharges during birth, or else to such external sources of irritation as prolonged exposure to a bright light, the use of strong soap, etc. Nurses usually have their own cherished methods of treatment, and often conceal the existence of ophthalmia from the medical attendant till they have fruitlessly tried their own favorite applications of warm milk, breast-milk, bread poultices, etc. The disease has frequently advanced so far by that time that several weeks of careful treatment are necessary to effect a cure; and in bad cases, when the cornea is much involved, the sight is often permanently

impaired or destroyed. With a view of preventing this distressing malady, Credé has made a careful study of 600 consecutive cases of new-born infants, and has recently published the results of his observations. In 300 of these cases he caused both eyes to be thoroughly cleansed with a soft rag during the first bath, and one drop of a two per cent. solution of nitrate of silver introduced into each eye. Although the conditions and surroundings of these children were most unfavorable, not one so treated suffered from ophthalmia. Credé confidently recommends this simple measure as a safe and certain prophylactic.

OBSTETRICS.

Notes of Labor in Deformed Pelvis.

CHAS. JEWETT, M. D. (Proceedings of Kings Co. Med. Soc.)

Case 1. Funnel-Shaped Pelvis.—M. S., æt. 35 years, of Irish birth, primipara, at term, fell in labor July 3d, '82. Dr. Jos. Healy being summoned July 6, finding the pelvic outlet too narrow to admit of delivery by ordinary means, requested the assistance of Dr. I. H. Platt and myself. When I reached the patient, about 12 P. M., I found the head on the pelvic floor, in occipito-anterior position. Here it was arrested by the inward projection of the ischia. The transverse diameter at the outlet was about three inches. The sub-pubic angle did not exceed 60°. The woman's pulse at this time was 130 and very feeble; the vagina hot and dry; the abdomen extremely tympanitic, and exquisitely tender on pressure. History of no fœtal movement for several hours; fœtal heart sounds not obtainable. Craniotomy was at once decided upon, and the operation was done by Dr. Healy. The cephalotribe was not available for

crushing the head as the space was too narrow to admit of locking the instrument without undue violence.

The child was a female of apparently not less than ten pounds. The head was large, and the bones of the cranial vault exceptionally hard and unyielding.

After the extraction of the foetus, the uterus contracted firmly upon the placenta. Owing to the excessive tympanites, expression by the method of Credé was impracticable. The placenta was therefore removed by the hand in the vagina. So narrow was the outlet of the pelvis that the uterus could be reached only with the utmost difficulty. The placenta was found wholly separated but firmly grasped in a globular cavity formed by the contraction upon it of the upper segment of the uterus. The opening into this globular cavity was barely sufficient to admit the finger. The portion of the uterus below the point of constriction was trumpet-shaped, expanding gradually from above downward.

In brief, the case was a typical one of so-called hour-glass contraction. By carrying the hand up into the cervix and slowly dilating the constriction with the fingers, the placenta was finally delivered.

The above case affords a good illustration of the real character of this accident, now so well understood through the teachings of Bandl.

Hour-glass contraction was formerly attributed to paresis of a portion of the uterine muscular wall; in other words, to irregular contraction. Now we recognize in it the simple result of normal uterine contractions taking place upon a wholly imprisoned placenta.

During labor, normally the greater mass of the uterine muscular fibers gradually gather into the upper segment of the uterus, whose walls thus become very thick. The lower uterine segment

is left extremely thin. The muscular ridge at the point of division between the two segments is the ring of Bandl. This point is at a greater or less distance above the true internal os-uteri. All that portion of the uterus below Bandl's ring, sometimes termed the obstetrical cervix, is generally in a flaccid condition for several hours after delivery, taking no part in the contractions of the third stage. If violent contractions now occur while the placenta is wholly in the upper segment of the uterus, the ring of Bandl is liable to be closed and the placenta imprisoned in the cavity above. The muscular action of the uterus which tends to expel the placenta when Bandl's ring is prevented from closing by a portion of the placenta lying therein, tends to imprison the placenta when it lies wholly above that point.

Obviously, the premature administration of ergot is liable to give rise to the above accident. Accordingly, in cases of hour-glass contraction, it is not infrequently found that ergot had been used during the second stage.

Despite the active use of restorative measures, the patient sank and died about sixteen hours after delivery.

Autopsy by Dr. A. H. P. Leuf, who kindly furnished notes from which the following extracts were taken:

Body of stout build and well-rounded development; height, 57½ inches; no spinal or other deformity apparent to the eye; spleen much softened; kidneys fatty. Peritoneal vessels injected here and there over the uterus and a portion of the abdominal wall.

The chief object of pathological interest was the pelvis, which strongly approximated the male type. It was removed, and after the soft structures had been cleared away I obtained the following pelvic measurements: Ilio-cristal, 10½ inches; Ilio-spinal, 9½ in-

ches; Conjugate, at brim, $3\frac{1}{2}$ inches; Transverse, at brim, $4\frac{9}{16}$ inches; Obliques, at brim, each, $4\frac{3}{8}$ inches; Transverse, at outlet, $3\frac{1}{16}$ inches; Antero-posterior, at outlet, $3\frac{1}{8}$ inches; Sub-pubic angle, 58° .

Case 2. Flattened Pelvis.—In contrast with the above case is another which I saw in May last, by the kindness of Dr. J. Corbin. The patient was a healthy German woman of 25 years, ii.-para, of full muscular development, having no spinal or tibial curvatures, but of exceedingly small stature—4 feet $6\frac{1}{2}$ inches in height. No history of rachitis. Diagnosis of flattened pelvis.

In her first confinement, she states, she was five days in labor under the care of a midwife and an irregular practitioner in New York. The child died immediately after birth.

In the second labor, the duration of the second stage was eight and a half hours. During this time the uterine efforts, which were of the most vigorous character, were expended in molding the head and overcoming the obstruction at the brim. The brim once passed delivery was accomplished in a single pain. Neither child nor mother experienced an untoward symptom during the lying-in period.

I obtained the following pelvic measurements after delivery: External conjugate, $6\frac{3}{4}$ inches; Ilio-spinal, $8\frac{1}{4}$ inches; Ilio-cristal, $10\frac{5}{16}$ inches; Internal conjugate, $3\frac{1}{2}$ inches; Other diameters, ample.

The child's head presented the average measurements.

A well-defined groove over the left temporal region marked the track of the sacral promontory.

The wisdom of the doctor's course in withholding the forceps in this case was amply vindicated.

It is worthy of note that in this class of cases—slightly flattened pelves—na-

ture boasts the best statistics—version stands next, while the mortality of forceps operations above the brim is something formidable.

The Great Frequency of Cardiac Murmurs in the Puerperal State.

Dr. JOHN WILLIAMS. The observations were made on 111 consecutive cases. Murmurs were heard in 84 cases, or about 75 per cent. The great majority of the murmurs were situated over the right heart. There were two cases of undoubted structural disease. The remaining great bulk of the murmurs are here dealt with. The patients who possessed a murmur for the most part did not suffer from symptoms referable to the heart. The time of the murmurs was invariably systolic. The murmurs are divided into three sorts. The first resembling an ordinary endocardial murmur, was most numerous; was of blowing character, soft, usually low or medium-pitched, fairly long and heard with almost every cardiac beat, and presented but little variation during the course of its existence. The number of these was 51; 36 were loudest over the tricuspid area, 8 over the mitral area, 6 over the pulmonary, and 1 over the aortic. By tricuspid area is meant the fourth left space, just a little to the left of left edge of sternum, there or thereabouts. The murmur was conducted to a variable extent. The duration of the murmur was variable. Most commonly the murmur was first heard a day or so after delivery. The mechanism of the murmur is discussed. The most novel and interesting, the "tricuspid" murmur, is believed not to be due to tricuspid regurgitation. No definite conclusion is come to as to the mode of production. The second kind (friction-like) was almost absolutely non-conducted, was heard over a very

small area just above and to left of ensiform cartilage. The murmur seemed superficial, was high-pitched and stiff in quality; was not audible with every cardiac beat. This sort was heard twenty-nine times. The mechanism is probably exocardial friction. The site would about correspond to the white patch which may be seen on the front of the right ventricle. The third kind of murmur, the least numerous, the most capricious, was remarkable for its loudness, was very inconstant—*i. e.*, not heard with every cardiac beat, and was very transitory; its area of audition was remarkably limited; it was most frequently heard over one or the other base of the heart; it commonly went with an excited action of the heart associated with pyrexia or mental emotion. Besides pyrexia, excitement, anemia, this murmur was sometimes associated with rales in the chest and with a cough, but no sputa. The quality of the sound varied. In many cases it resembled the sound evolved when a piece of silk tightly stretched is scratched with the nail; or like the sound heard when pressure is made on the carotid in anemic cases. Sometimes the sibilant rale was almost exactly imitated. The murmur was in all cases heard when the breathing was stopped. The mechanism of this murmur is discussed. The murmur was heard sixteen times. The mode of generation of murmurs is regarded as very puzzling. All the murmurs of the second and third kinds, and a majority of the first kind, were temporary phenomena. Murmurs in the puerperal state are (for the most part) not indicative of the appearance of serious cardiac lesions.—*London Lancet.*

Case of Extra-Uterine Fœtation Treated by Antiseptic Abdominal Section, with Removal of Fetus and Hypertrophied Placenta; Recovery.

Paper on this subject was read by Mr. KNOWSLEY THORNTON. The early history of the case was narrated at the March meeting of the society. The author would divide cases of extra-uterine fœtation into three classes: 1. Those in which accurate diagnosis is possible. 2. Those in which probability, but not certainty, in diagnosis can be reached. 3. Those in which the nature of the case is not suspected until internal hemorrhage, or other untoward accident takes place. In classes one and three, he thought it bad practice not to operate; in class two, an exploratory operation should be performed if the symptoms were urgent. But such operations should only be performed: 1, under strict Listerian precautions; and 2, by a surgeon of special experience in abdominal sections; for they are extremely difficult. Dr. Routh said that, wherever there was a growing abdominal tumor, and a complete decidua was voided *per vaginam*, the diagnosis of extra-uterine fœtation might be made. The successful removal of the placenta in this case was due to its hypertrophied condition. Possibly the placental souffle heard over fibroids was not so marked as that of the placenta. He thought the presence of milk in the breast would aid diagnosis. The President drew attention to the persistent life of the placenta after fetal death, and its great hypertrophy. He did not believe the souffle was placental; he called it uterine. The discharge of an entire decidua was a valuable diagnostic aid. He remembered a case in which such a decidua was passed; rupture of the sac and internal hemorrhage took place. After a few days, he evacuated the hem-

atocele *per vaginam*, and found chorionic villi in the fluid. The patient did well. Nowadays, he would have had laparotomy done to get the bleeding stopped. Mr. Thornton said that the souffle was not heard; had it been, it would have strengthened in his opinion, the diagnosis of fibroid tumor. The case narrated by the President was a very rare one. He thought that now abdominal section would have been attended with less risk than the course followed.—*Lancet*.

Nitro-Glycerine in Puerperal Convulsions.

Mr. W. E. GREEN reports the following case of puerperal convulsions, treated successfully by nitro-glycerine :

On August 21st I was called to a case of prolonged labor, but as I found the head presenting and all things doing well, I left.

On a second call a few hours afterward, I found my patient in convulsions, the head of the child well down upon the perineum. I then used forceps and delivered. On removal of the placenta a rush of blood followed, but was soon stopped.

The convulsions had ceased, but the coma still continued; the pulse was quick and high, eyelids puffy, legs edematous, and feet cold. I ordered eight minims of a one per cent. solution of nitro-glycerine to the ounce of water, a teaspoonful to be taken every hour.

Within ten minutes after taking the first dose, consciousness returned, the coma having lasted two and a half hours. In the evening, after the patient had taken four or five doses, the pulse was soft and quiet and she was comfortable in other respects. Her convalescence was slow, until the child was taken from the breast, when she made a rapid recovery.

The reason for using nitro-glycerine,

was the similarity between the symptoms of puerperal eclampsia and uremic convulsions. It is supposed to act by dilating the blood vessels, thus relieving the arterial tension caused by imperfectly depurated blood, due to pressure upon the renal arteries by the gravid uterus. The author likewise reports a case of uremic convulsions, in which he used it with evident benefit to the patient. He also claims for it an aperient action, which is very beneficial in such cases.—*British Medical Journal*.—*Med. Gazette*.

Etiology of Puerperal Eclampsia.

The author, Halbertsma, still holds to the theory he advocated in June, 1881, that puerperal eclampsia is, in many cases, caused by the pressure of the enlarged uterus upon the urethra. He claims that all other theories, especially in cases in which the urine is free from albumen and no kidney disease exists, are easily disproved. Post mortem examination will not aid in proving his theory, as the obstruction is removed as soon as the uterus is empty; but swelling and catarrh of the urethra, caused by the pressure, may be, and are, found. As further proof, he draws attention to the kidneys of pregnant women, the epithelium of which, according to Leyden, undergoes fatty degeneration, on account of disordered circulation and not from venous obstruction.—*Deutsche Med. Zeit*—*Ibid*.

Puerperal Eclampsia.

The author (Brens. Wien) recommends as treatment in puerperal eclampsia the warm bath and wrappings in order to produce abundant diaphoresis.

He places the patient into a bath, the temperature of which is 38°-40° C., and, by the addition of warm water, raises it to 42°-45° C. He allows them

to remain about half an hour, then places the patients in warm wraps, in which they are kept for three or four hours.

In two cases of puerperal eclampsia treated in this way, no miscarriage occurred, the one giving birth to a child at term, the other had a premature birth five weeks afterwards.—*Ibid.*

Cæsarean Section.

Prof. SPÄTH reports a successful cæsarean section. The patient was twenty-one years old; primipara, with a contracted pelvis. The operation was after Porro, modified by Müller. The child was not asphyxiated, weighed 2140 gram., and measured 42 cm. Iodoform dressings were used.—*Ibid.*

Fœtus in Fœtu.

Dr. LUBIMOFF, Kasan, Russia (*Vratch Vedomosti*, No. 1, 1882), has recently reported an interesting case of this kind. He found on a little girl, born at term and living, a perineal tumor of which the right half was hard and the left half soft. On autopsy there were found two cysts in the left half. The right half contained different portions of a fœtus, a well-developed foot with six toes, a rudimentary arm and a stomach. Between the two tumors were found small dermoid cysts containing epithelial cells, striated muscular fibre, bits of cartilage, and bones containing marrow in the interior.—*Chic. Med. Review.*

Procidencia in the Fifth Month of Pregnancy; Replacement and Delivery at Term.

Dr. V. G. WEBB (*Brit. Med. Journ.*) reports a case in which a woman, after carrying a bucket of water, had bearing down pain on the following day, inversion of the vagina, and extrusion of the

uterus five or six inches from the vulva. The parts were oiled, reduction effected, and a Greenhalgh's spring pessary introduced. Lead injections were ordered with rest in bed. After five days inflammatory symptoms had subsided, and she was allowed to get up. The pessary was worn four months without discomfort. Four and a half months after the accident normal delivery occurred, and after fourteen days the patient resumed her household duties without any subsequent discomfort.

The Corpus Luteum.

At a meeting of the Obstetrical Society, of London, Dr. W. A. POPOFF, of Pensa, read a paper on this subject. In it he described the case of a prostitute, aged 21, dying of prussic acid poisoning, in which he found a fully ripe corpus luteum, although the woman was neither pregnant nor menstruating. The President (Dr. Matthews Duncan) said it was important to have the view confirmed that a corpus luteum, having all the characteristics of that met with in pregnancy, occurred in women who were neither pregnant nor menstruating. He had seen such a corpus luteum in an aged woman who was believed to be salacious, and he had dissected cases of pregnancy with complete absence of corpus luteum.—*Canadian Journal of Medical Sciences.*

Static Electricity as a Galactagogue.

Dr. BLACKWOOD reports three cases in which he has obtained excellent galactagogue effects from the application of static electricity to the breasts. In two cases this success followed the utter failure of the other methods of treatment, while in the other case this treatment was the only one attempted.—*Phil. Medical Times.*

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Cancer of the Cervix Uteri.

Dr. WM. H. POLK (*Med. and Surg. Reporter*). Clinical lecture.

This woman is about fifty years of age. She had perfect health until four months ago; her circumstances were passably good; she suffered no bodily aches or pains; there was no derangement of function of any of the organs of the body. She had completed the menopause about three years before, and until four months ago, as said before, her health was as good as that of any woman at her period of life. At that time, however, she was suddenly startled by a feeling of something trickling down from the vagina, and, on examination, found some blood, which continued to flow, during three or four hours; quite profusely. It then ceased, and she gave the matter no more thought, until ten days afterward, when it reappeared under almost the same circumstances, lasting this time twenty-four hours. These irregular hemorrhages have continued to return, at times, from then until the present. This being the case, her general health became affected, and she was forced to come here, seeking for relief. When she came into the hospital she had the appearance of a woman who had been losing blood; but she suffered from no pain, and remarked, "Doctor, if you will stop that bleeding I will be as well as any woman here." But the moment I put my finger into the vagina I found that she was very far from being as well as any woman in the house. In other words, I found the cause of her bleeding to be an

epithelioma of the cervix. Let it be your rule, gentlemen, when a woman who has passed the menopause a year or two before, comes to you complaining of loss of blood from the vagina, to suspect cancer of the uterus, and in the great majority of instances you will find your fears verified on examination.

The usual appearances of a cancerous development on this part I have spoken about before. They are very well shown in this patient. But the point arises, what shall we do for her? There have been a number of operations proposed. In the first place, amputation of the cervix. This, of course, is based entirely upon the supposition that only so much of the cervix is involved as can be totally removed by the knife, scissors or galvano-cautery. If, however, the disease has gone up to the vaginal junction and invaded the deeper portions of the uterine structure, simple excision of the cervix will accomplish nothing. The only resource would be to remove as much of the diseased tissue in this way as we could then scoop out as much as possible of what remained, using the actual cautery in order to prevent hemorrhage. This latter operation is the only one which can be adopted in the present case, for the disease has gone quite up to the vaginal junction, invading deeper portions of the uterus and neighboring glands. All we can do, therefore, is to get rid, as far as possible, of this fungous-like growth, which is so sensitive to the touch that even a jar is sufficient to produce a loss of blood. If we can remove this satisfactorily the loss of blood may be checked so that her general health may improve.

With regard to another operation, total extirpation of the uterus, I merely mention it, as it was suggested in the present case, and would say that it was absolutely forbidden on the discovery of involvement of the lymphatics of the pelvis. Total extirpation of the uterus is to be resorted to only in case all the diseased tissue can be removed.

You will observe that after removing this tissue with the scissors I am able to check hemorrhage by means of the actual cautery, which is kept constantly ready for use during the operation, as considerable hemorrhage may occur at any moment. Of course, we do not perform this operation with any idea of curing the disease, but simply, as far as possible, to relieve symptoms.

Cæsarean Section Followed by Ablation of the Fundus Uteri (Porro's Operation).

M. GUICHARD reported to the Société de Chirurgie, Paris (session of May 3-10, 1882), the following case: The patient, 25 years of age, measured only 1.08 m. (42½ inches) in height; she presented a marked kyphosis occupying the lower part of the dorsal region. Arriving at full term, the uterus revolved downward and forward, and formed a large tumor like a bag descending almost to the knees. Digital examination revealed a narrowing, obliquely oval, of the superior strait; but the principal obstacle was seated at the level of the inferior strait, which measured in its transverse diameter only 4 centimetres. Cæsarean section was performed, and a child extracted, which survived. Immediately afterwards he excised part of the uterus, and the pedicle was included in the suture of the abdominal wall. The rules of the antiseptic method were rigorously carried out. On the second day a slight hemorrhage required the application of an elastic ligature. The pa-

tient died the next day, with symptoms of peritonitis. The skeleton of the woman was presented, which was remarkable for its vertebral curve and the form of the pelvic basin.—*Bulletin Général de Thérapeutique*.—*Med. Times*.

[On reading the above we are again led to ask how many more mothers and children will be sacrificed before the profession will be led to give Laparotomy a fair trial.] A. J. C. S.

Spontaneous Elimination of Uterine Fibro-myomata.

The causes of such elimination are various; a submucous fibroid, urged by its growth or muscular action (spontaneous, or excited by ergot), pushes the uterine mucous membrane before it until it becomes a fibrous polypus with a pedicle. Coughing, vomiting, straining, &c., presses it out.

Dr. FRANK FUNK related cases in his own experience in which proper remedies brought about spontaneous elimination. But the physician should not wait for this; as soon as it appears in the cervix he should remove it. In one case, in which there was delay in removal, death was caused by self-infection.

The lower part of such a growth is badly nourished, becomes irritated by friction with other parts, and gangrene results. Such operations may be undertaken during menstruation, they being more accessible, and hemorrhage is not so much to be feared. On the contrary, in case of a retained placenta in abortion, a passive attitude should be maintained as long as possible. Seated in the uterus, it is well nourished, and infection is not to be feared. But seated in the cervix, it should be immediately removed, it being there similar to a protruded polypus. The tumor may press on the peritoneum until, torn from its

place, it falls into Douglas' space, and is eliminated through the rectum, bladder, etc. It may become softened through suppuration of its capsule, or it may become gangrenous. He had a subserous polypus under his care, which, after an abortion, followed by endometritis, suppurated and was passed through the rectum, vagina and bladder. It could not have been submucous, as the vaginal portion of the cervix was vaginal. She recovered in three months. Another form of elimination is that in which the new growth becomes necrotic, forms inflammatory adhesions with its surroundings, and is cast out in different ways.—*Obstet. Gazette.*

A New Method of Treating Inveterate and Troublesome Displacements of the Uterus.

Operations for these troubles, says Dr. ALEXANDER, are a last resort when all appliances have failed, or to obviate the disagreeable necessity of wearing a pessary. He speaks almost solely of those forms of displacement which are accompanied with prolapse. One of the chief agents concerned in such a displacement is the round ligament. The anatomy and function of this are very clearly and accurately described, the description following Quain. Since, in a condition of prolapse, this ligament, on either side, is stretched, replacing the uterus does not at once restore the normal tone of the ligamentous tissue, or, to copy the author's idea, there is a *slack* in the ligaments which prevents them from giving the proper *quantum* of support. He proposes to remedy this by an operation to "pull out the slack of the round ligaments." The idea is entirely novel and we reproduce the author's description: "The operation is performed by cutting down upon each abdominal ring, gathering up the ends of the ligaments, free-

ing each from its nerve, and gradually releasing them, by patient and cautious traction, from the neighboring tissues, until the position of the uterus, as ascertained by the finger in the vagina, satisfies the operator. The ligament is then stitched to the tissues around the ring, and the loose ends attached to each other, or rolled around two pieces of wood which are fastened together in the middle line. The picking up of the ends of the ligament is the difficult point, and the freeing of the ligaments from their surroundings is the delicate point, but, by experience, both can be performed easily and effectually. The ligament slides within its sheath, and the peritonæum is not disturbed. No risk of hernia or pelvic inflammation occurs. Beyond some pain for the first few days, the operation is harmless, if carefully performed, but experiments on the dead subject have shown me the danger that may arise from incautious operators." Four cases are detailed in which this operation was performed. In the first, the patient being thirty-eight years of age, the cervix presented external to the labia. The operation for narrowing the vagina was first done, and, though that operation was successful in accomplishing the end referred to, the tension upon the bladder and rectum was not relieved. Two months and ten days after the first operation that upon the round ligaments was performed. Two inches of the *slack* in each were pulled out and cut off, and the ends were stitched by catgut sutures to the boundaries of the wounds. The wounds healed kindly, and there was not much accompanying pain. The cure was satisfactory, the uterus being firmly held in the position to which it had been drawn at the time of the operation. Pregnancy is not probable after this operation. Should it occur, three consequences are possible: 1. The uterine

might not be able to rise into the abdomen, and abortion would take place. 2. The ligaments might give sufficiently to allow the uterus to rise, and then retract after parturition. 3. They might fail to retract, and prolapse would recur. The author thinks the main object has been attained when cohabitation becomes possible, and that his operation is likely to secure this end.

In the second case the result was the same as in the first. Bronchitis induced by the ether inhaled at the time of the operation caused recovery to be slower than usual, more painful on account of the strain from coughing, and healing of the wound to take place by granulation. Where there is a tendency to bronchitis, chloroform anæsthesia is recommended during the operation.

In the third case the patient was cured without complications.

In the fourth, obstinate retroflexion was the cause for which the operation was done. Only one of the round ligaments was properly caught up, and the uterus was held in position by this, the retroflexion being quite cured. In this last case, and in another not here described, there had been difficult and painful menstruation, which was relieved by the operation. Before operating upon the living subject the author recommends experiments upon the cadaver.—*N. Y. Med. Journal*.

The Natural History of Dysmenorrhea.

A paper was read by Dr. JOHN WILLIAMS on the above subject, of which the following is a summary :

1. Dysmenorrhea should be studied first under the least complex conditions—in single women. 2. In single women it is rarely acquired; it is almost invariably primary; *i. e.*, it appears with the menstrual function. 3. In a few but rare cases, it ceases spontaneously a few

years after puberty. 4. Marriage, if sterile, aggravates the disorder in many cases; it is only very seldom that it relieves the pain. 5. Child-bearing cures a large number of cases, and it is not improbable that were all puerperal complications excluded, it would cure every case. 6. The proportion of sterile to fertile women subjects of primary dysmenorrhea is one to twelve. 7. Menstruation begins in women who become sufferers from primary dysmenorrhea at about the estimated average age for the appearance of that function in London. 8. Menstruation is regular in about two-thirds of the cases, and irregular in about one-third. 9. The menstrual fluid is profuse in about two-fifths of the cases, scanty in about one-half, and contains clots or shreds in about three-fourths. 10. The changes which take place in the fluid in the course of dysmenorrhea are various, and cannot at present be classified. 11. The uterus is imperfectly developed. It may be too short or too small in volume, or it may be defective in both respects. The cervix may be conical and the os small and round, but stricture of the canal in any part of its course is infinitely rare. 12. The changes in the uterus due to dysmenorrhea are slight hypertrophy, erosion and eversion of the mucous membrane of cervix, and catarrh. The cavity increases but little in length, for, after years of suffering, it measures rarely more than two and one-half inches in length. In the early stages, the tissues of the uterus are in some cases soft; in more advanced hard. 13. The hypertrophy of the uterus is probably the result of periodically increased muscular action. 14. Ovaritis and perimetritis are possible consequences of dysmenorrhea. 15. The menstrual pain is the result of spasm of the uterus, excited by the separation and expulsion

of shreds of decidua and clots in an organ whose sensitiveness in the performance of its function is enhanced by inappreciable conditions of tissue dependent on imperfect development, often associated with others, such as anemia.

Dr. Savage said that the broad ligaments were never unsymmetrical. The uterus was always the centre of it. Apparent elongation of one side was due to deficient uterine development on that side. Uterine casts never contained glands, but only circlets of cells surrounding the apertures of glands. Fragments of casts more or less minute always came away with menstrual fluid.

Dr. Robert Barnes agreed that imperfect development of the uterus was a factor in dysmenorrhea, though he thought Dr. Williams' estimate of the proportion was too high. The frequency with which pregnancy followed the treatment of dysmenorrhea showed that the uterus was fairly developed. He believed also that Dr. Williams had underestimated the frequency of acquired dysmenorrhea in single women. From retroversion or other causes dysmenorrhea might be produced. The two most frequent causes of dysmenorrhea and sterility, in his opinion, were a narrow os externum uteri and flexion. Where one or both of these conditions were present, dysmenorrhea would commonly persist until they were remedied. He was pleased that Dr. Williams did not adopt the unphilosophical doctrine of spasmodic dysmenorrhea as a primary or essential condition. Enlargement of the uterus was due, not only to excessive muscular action, but to constant congestion of the organ from its impeded circulation. This produced a subacute endometritis, and the shedding of dysmenorrheal membranes. By the enlargement of a narrow os externum access was gained to the uterine cavity, so

that the unhealthy mucous membrane could be directly treated.

Dr. Wynn Williams could not agree that displacements were not acquired in virgins. He had noticed that falls on the back commonly produced retroflexion; on the face, antelexion. In his experience, the most frequent and persistent came of dysmenorrhea was antelexion, which could only be cured by permanently straightening the uterine canal; and this he believed could be done. He agreed with Dr. Barnes as to the importance of a small os externum. He thought the author had not laid sufficient stress on metritis and fundal endometritis as causes of dysmenorrhea.

Dr. Graily Hewitt had remarked the frequency with which general malnutrition, involving also the uterus, was observed with uterine symptoms. In these cases, during the early part of their course, the uterus was soft, incapable of maintaining its proper shape and position, and hence became flexed, prolapsed, or compressed upon itself. Probably some of the cases described by Dr. Williams as cases of imperfect development were of this latter kind. One of the symptoms that arose was dysmenorrhea, due to difficulty in the escape of secretions, owing to the altered shape of the organ. All cases of uterine distortion were not accompanied with dysmenorrhea; nor was dysmenorrhea always due to uterine distortion. The circulation of the uterus was often much interfered with, and the congestion might cause pain. He hardly ever failed to relieve dysmenorrhea by measures to keep the uterus in proper position and its canal straight; and this seemed to him conclusive as to the connection between the distortion or displacement and the dysmenorrhea. He thought, in opposition to Dr. Williams, that dys-

menorrhœa was often secondary.—*Am. Journal of Obstetrics.*

Dysmenorrhœa.

Dr. L. L. LEEDS, of Lincoln, Ill., writes us that he has found the tincture of pulsatilla, given in half-drachm doses thrice daily during the interval, to be a most excellent remedy in this affection.—*Med. and Surg. Reporter.*

Membranous Dysmenorrhœa.

℞. Pulv. guaiaci res; terebinth. canadensis, āā 1 ounce; ol. sassafras, 2 drachms; alcoholis, 8 ounces.—Mix. Macebate for seven days and strain. Then add—Hydrarg. chlor. corros., 1 scruple.—Sig. Take twenty drops in wine or sweetened water, night and morning.—*Va. Medical Monthly.*

Treatment of Amenorrhœa.

A large number of remedies have been credited with emmenagogue properties, many of them being inert, and some of them simply irritant poisons whose employment has frequently resulted fatally, especially when used with criminal intent, as abortifacients. Strychnia affords excellent results in many instances. A favorite with me is the following:

℞. Strychniæ sulph., gr. j.; dextro-quinia, 3 j.; ferrum per hydrogen and asafetida pulv., āā 3 ij.; ext. quassia, q. s.—M. In pil. No. 60 div. Sig.—One four times daily.

I usually add at bedtime ten drops of Squibb's fluid extract ergot in water, and a forcible jet of cold water along the spine every morning on rising for a few minutes, with brisk friction of the abdomen, succeeds admirably in many cases. Exercise in the open air, equestrianism particularly, with attention to a normal

action of the skin, kidneys and bowels, is essential.—*Medical Summary.*

[We have frequently used strychnia and ergot in menorrhagia with apparently good results. This leads us to think that these remedies may have had very little effect in amenorrhœa in the cases given above. The menstrual function is often recovered in time under any course of treatment which improves the general health.] A. J. C. S.

DISEASES OF CHILDREN.

Treatment of Infantile Gastro-Enteritis.

From observations made in the Children's Hospital at Pesth, Epstein concludes (*Prayer Medic. Wochens.*) that a liquid diet, poor in fatty matters, is the basis of treatment of gastro-enteritis in young infants. He recommends particularly an albuminous lemonade, obtained by beating up the white of an egg with a pint of water, previously boiled, the resulting mixture being then carefully filtered. At the Pesth hospital this is prepared fresh three times daily, and is kept in a bottle well corked, and placed on ice. In a word, all precautions are taken to prevent the introduction of micro-organisms into the system.

Nursing from the breast should be completely stopped for the first few days. Every three hours, fifty grams of milk at a lukewarm temperature may be given to the child, either with the bottle or by spoonfuls. The child should not be put back to the breast until the loss of flesh, which is considerable at first, commences to diminish. Again, when at the commencement there is violent vomiting and rejection of yellowish curds, M. Epstein washes out the stomach daily, for from eight to fifteen days, by means of the œsophageal tube.

As regards direct remedial measures, M. Epstein employs the following potion :

R. Sodæ et magnes. benzoat., \mathfrak{D} iv. ;
sp. vini gall., 3 ss. ; aquæ, \mathfrak{z} vj. M.
Sig.—Teaspoonful every two hours.

When there is any tendency to collapse, recourse may be had to the following :

R. Tr. valerian, 3 ss. ; vini port (pur.) ; æther. sulph., \mathfrak{aa} . 3 ss. M.
Sig.—One or more drops of this mixture may be given in a spoonful of water.

When the child presents any sign of cerebral hyperæmia, with great agitation, chloral in small doses may be prescribed :

R. Choral hydrat., grs. viij. ; aquæ, 3 xij. M. Sig.—A teaspoonful of this solution may be given every half hour while excitement continues.

Finally, when inflammation has reached the large intestines, and symptoms of dysentery supervene, it may be attacked directly by the following enemata :

R. Ac. boracic., 3 ss. ; aquæ destill., \mathfrak{z} ij. M.

Or with—

R. Argenti nitrat., gr. xij. ; aquæ destill., \mathfrak{z} ixss. M.

The results obtained from this course of treatment are, it appears, excellent.

Enteralgia in a Child—Quinine and Iron Cure.

W. H., aged six years ; seen February 6, 1872. During last four years he has had attacks of pain in the abdomen and vomiting continuing for fourteen to sixteen hours, occurring more frequently of late. He used to be very stout, but has fallen away very much. Appetite is bad, he does not eat nearly as much as he used ; sleeps pretty well ; tongue natural ; bowels open ; no fever ; is not anemic. The abdomen seems to be natural ; it is flat and resonant, except in the region of the liver, where there

is dullness extending nearly to umbilicus ; his flesh does not heal well, and he had an abscess in the right groin four years ago. The pain is very severe when it comes on ; occurs in paroxysms, which cause him to jump up and scream. He has been so ill in some of these attacks as to appear dying. Ordered ferri et quinæ citrat., gr. iv. ; spt. æth. chlor., \mathfrak{M} v. ; aq., \mathfrak{z} j. t. d.

March 2.—Is much better ; has not had an attack since he commenced to take the medicine.

March 16.—No attacks ; is hungry and eats with appetite.

January, 1873.—He remains very fairly well.

March, 1875.—Has lately had a recurrence of the same disorder, which has been arrested by the same means.

Enteralgia in children is rather a rare disorder, as, indeed, neuralgia affecting any other locality is. Pain of other kinds is so much more common that a practitioner may well be excused if he does not always appreciate immediately the true nature of such disorder as is exemplified in the above case. In the first it is important to remark that some amount of fever was present, which would naturally raise a suspicion that the disease was typhoid, and that the pain was produced by intestinal ulceration. Strong points against this view would be the absence of tenderness of the abdomen, the long complete intermissions of the pain, its severity when present, and the night temperature being too low for typhoid. Another view might be entertained that the child was the subject of *tabes mesenterica*, and that the intestinal lesion caused the pain and fever. Against this was the recent invasion of the disorder, the absence of diarrhœa and of tenderness, as well as the extreme severity of the pain and its intermittency. Lead poisoning

was considered as a possible cause of the pain: but the inquiries made gave no countenance to this idea, and the success of tonic treatment negatived it. Both these children lived in Paddington, near the canal, but not in its immediate proximity. I have often been inclined to suspect that emanations from this water-way gave rise to malarial disorders, but have never obtained any clear evidence that such was the case.—*Med. Press & Circular*.—*Louisville Med. News*.

On the Treatment of Convulsions in Children.

EUSTACE SMITH, M. D., F.R.C.P.
(*London Lancet*):

When called to a case of convulsions the practitioner should lose no time in questioning the attendants, but should have the child placed in a warm bath of the temperature of 90° F., and apply sponges dipped in cold water to his head. This is the time-honored remedy. It is certainly an innocent one; it may tend to quiet the nervous system; and it is one the efficacy of which is so generally recognized among the public that it would be unwise to court unfavorable criticism by neglecting to employ it. The bath must not be continued too long. In ordinary cases the child should be allowed to remain in it for ten or fifteen minutes, according to his age. If, however, the patient be an infant who has lately been reduced by an exhausting diarrhœa, he should not be allowed to remain more than two or three minutes in the hot water, and cold applications to the head must be dispensed with. If the convulsions have ceased when the case is first seen the bath need not be used; but we should not omit to have the child competely undressed, and then to see that he is placed, lightly covered, in a large cot, and that the room in

which he lies is well ventilated and not too light. Care should be taken to unload the bowels by a large enema of soap and water, and if the child be noticed to retch, his stomach may be relieved by a teaspoonful of ipecacuanha wine. In the case of a teething infant opinions differ as to the propriety of lancing the gums. There is no doubt that this operation is a useless one if employed with any hope of hastening the evolution of the teeth; but if the object be to relieve pain and tension I consider the practice judicious, and never hesitate in such circumstances to have recourse to it. If it be desirable to remove all sources of irritation, surely such a source of irritation as a swollen and inflamed gum should not be disregarded. Lastly, if it can be discovered that the child has had pain in the ear, or if the tympanic membrane can be seen to be red, the ear should be syringed out and fomented with hot water, and, if thought desirable, a leech may be applied within the concha, the meatus being first plugged with cotton wool.

If, in spite of these measures, the convulsions return, or signs are noticed of continued irritability of the nervous system, it is best to administer a dose of chloral. Two or three grains can be given to a child between six and twelve months old; and if the patient be unable to swallow, half as much again may be administered by the rectum dissolved in a few teaspoonfuls of water. If necessary, the dose can be repeated two or three times a day. Bromide of ammonium and belladonna are also largely employed in these cases. The former can be given in three or four grain doses every two hours to a child of from six to twelve months old; the second in ten or fifteen drop doses two or three times a day to a child of the same age. Infants are so tolerant of this drug that it should

be given to them in a dose which can produce some appreciable effect. In the convulsions of whooping-cough where the spasm of the glottis is extreme, treatment by bromide of ammonium or potassium is especially indicated. The bromides are well borne by quite young children, and we should not fear ill consequences from what may appear a very large dose. Chloroform is often employed, but it is decidedly inferior to chloral and much more troublesome.

If the child has been lately the subject of exhausting discharges warmth should be employed, and stimulants, such as the brandy-and-egg mixture of the British Pharmacopœia, be given energetically. If the convulsive attacks are followed by signs indicative of intracranial mischief, such as stupor, squinting, ptosis, etc., the child should be kept quiet and an ice-bag be applied to his head. In all such cases the treatment must be conducted according to the condition from which the convulsion is supposed to have arisen.

When the convulsions have ceased, and signs of irritability of the nervous system are no longer to be observed, we must take steps to improve the general condition of the patient. His bowels should be attended to and his diet be carefully regulated. If rickets be present it must be treated. Most children in whom the convulsive tendency exists are benefited by iron wine and cod-liver oil, for their nutrition is usually at fault, and both the alcohol and the iron contained in the wine are beneficial, while the oil is of the utmost value in supplying nutritive deficiencies. Fresh air, too, is of the utmost importance, and the child should be warmly dressed and be taken regularly out of doors.—*Louisville Med. News.*

Narcotism in Infancy.

Dr. H. CRIPPS LAWRENCE says, in the *Practitioner*:

Given a healthy child to start with certain results will follow the administration of narcotics, with an equally certain regularity.

1. In the early administration of a narcotic, more or less diversified, according to the temperament of the infant, a modified degree of excitement will supervene, to be followed by sleep; and this favorable condition of things may recur for a period varying from a few days to a week or two. If, however, the repetition of the narcotic be at all frequent, or if it be exhibited in any but a very small amount, this period of favorable narcosis will be proportionately diminished, and the chances of its lethal effect increased.

2. In some infants the effects of the narcotic will be to speedily constipate, for, as in the adult, so in the infant, a narcotic lessens at once the secretions and movements of the stomach and intestines, and consequently digestion becomes arrested.

There is, however, a class of cases met with in infancy, wherein infants, the subject of imperfect digestion associated with colic, become for a time benefited by a moderate amount of narcotic. Here the sedative acts by checking peristalsis, and so enables the food to remain a longer time in contact with the digestive juices, and thus to become more perfectly digested. This condition, however, is more frequent in early childhood than in infancy.

A third and more frequent sign of the administration of a narcotic in the infant is the occurrence, sometimes the concurrence, of diarrhœa and vomiting. When these occur a longer time will elapse than when such conditions are

absent, before profound narcosis ensues.

3. In addition to the above, diaphoresis and diuresis may occur, one or both. Either of these may and often will be present in an inverse proportion to the other. The predominance of either will be dependent upon the amount of fluid ingesta, the character of the fluids taken, and the condition of the temperature of the weather present at the time. Obviously, warm weather or an over-heated atmosphere will promote diaphoresis, while cold weather would augment diuresis.

4. The intestinal evacuations soon alter in character, becoming paler and more solid in consistency, diminished in their frequency, and increasingly more and more deficient in bile, accompanied by a change in color, from yellowish-green to verdant green, with or without mucus, and if very constipated, accompanied by streaks of blood, owing to the tenesmus which is associated with the expulsion of the hardened, ill-digested feces.

5. Another vital symptom, though of later occurrence than the preceding, is marked depression of the vital powers, evidenced by sinking of the anterior fontanelle. This is accompanied by other signs of want of vitality, viz., feebleness of pulse, loss of weight, an earthy complexion, wasting, especially marked in the pinched and anxious expression of the face. By this time the infant alternates between efforts at peevish whimpering and imperfect somnolency.

The pupils will be found, in the earlier stages of narcotism in infancy, to be frequently contracted, but when the stage of fontanelle depression is reached they may contract or dilate, and one pupil may be larger than the other. This condition I believe to be dependent

upon variations in the amount of fluid present in the ventricles of the brain.

So soon as this stage is reached, any subsequent dose of a narcotic may prove speedily lethal, and the greatest care and caution become necessary to avert an untoward result. It is at this point that I believe the cumulative effect and action of the narcotic assumes a point of much peril to the infant. One of two results may now supervene; either clonic convulsions may set in, though these are not very frequent, or, and much more commonly, profound and perhaps fatal coma.—*Med. & Surg. Reporter.*

OBSTETRICS.

The Diagnosis and Treatment of Chronic Inflammation of the Ovary.

LAWSON TAIT, F.R.C.S., Surgeon to the Birmingham Hospital for Women, contributes the following to the *British Medical Journal*:

The diagnosis of pelvic diseases may be said to have received its first real life from Simpson; for, before his day, no such attention was given to these affections as deserved the name of systematic study. He it was who instituted precise means of physical diagnosis, and upon that he reared methods of treatment which have made a lasting impression on our practice. Like all innovations, Simpson's methods led, even in his own hands, but mostly in those of his friends and followers, to an excess of zeal; and the mechanical school of gynecology, of which he was unquestionably the founder, led many to the belief that, armed with a sound, a speculum, a caustic-stick, and some new-fangled pessary, the practitioner could subdue all the pelvic ailments of women. All these aids, valuable in their way, had their en-

thusiastic supporters, were declaimed against by others, did an infinite amount of mischief in their turn, and have, finally, been referred to more limited and less hurtful fields of practice.

From the same phase of surgical development arose a number of operative proceedings, each of which has extended our means of relieving human suffering, but each of which went through a course of rough experimentalisation which is now terrible to look back upon. Simpson found that division of the cervix relieved the sufferings in certain cases of dysmenorrhœa, and enabled a few sterile women to become pregnant. Immediately, we had a flood of hysterotomes all over the world, and every sufferer had her cervix divided. Thousands of wholly unnecessary operations of this kind were, and many still are, performed, and not a few deaths occurred from the practice.

Coincident with this innovation, we had the employment of pessaries, fortunately a less hurtful practice, but carried to an extent of uselessness which is positively amusing; and other illustrations of similar strivings in the dark might be given.

From the writings of Dr. Henry Bennet and Dr. Tilt, especially the latter, another new departure was derived; for attention was directed by these authors to the possibility of the ovaries being the seat of the troubles, relief from which was sought in the treatment of the uterus.

Still another impetus, and the greatest of all, in my opinion, was given to gynecology by Dr. Thomas Keith, who taught us that our traditional fear of the peritoneum was only a bugbear, and that it would serve us as well as any other part of the body if dealt with fairly. After Mr. Spencer Wells had gone on for twenty years operating on hundreds of

cases of ovarian tumor, with a mortality of about twenty-five per cent., Dr. Keith persuaded us that ovariectomy could be done with less than six per cent. of deaths. The mortality of Dr. Keith's and my own is now as low as three per cent., and this after we have both tried the so-called antiseptic system of Lister, and have given it up as more dangerous than useful.

The outcome of such splendid work in the removal of ovarian tumors will soon be felt in very many ways, but in one it has already given evidence of another and altogether new direction for abdominal surgery. As long as Mr. Spencer Wells's example ruled our practice, and as long as his high death-rate was the best we could get, we operated on ovarian tumors only when they threatened life, and we delayed the case by mischievous tappings as long as we could. We felt that we were not justified in opening the abdomen for conditions whose severity did not threaten life. Now, however, when the removal of an ovarian tumor is fatal only when the patient has been tapped, or the operation injudiciously delayed, we are justified in performing abdominal section, not merely for the saving of life, but for the relief of suffering.

This new practice has had many good results, not the least of which is, that it is shedding a whole flood of light on the pathology of pelvic disease, and is even helping us to understand the physiology of the female sexual organs. Thus my own practice, the details of which will shortly appear in a special work, has convinced me that the usually accepted doctrine of the coincidence of ovulation and menstruation is wholly erroneous. The ovaries have nothing to do with menstruation; and though I give the opinion with a qualification which may be made necessary by further experience,

so far the evidence before me is convincing that the phenomenon of menstruation depends upon the Fallopian tubes and not upon the ovaries. Finally, and of most importance for my present purpose, we are for the first time becoming cognizant of the real conditions involved in the disease recognized as chronic inflammation of the ovaries. For such a purpose as this, an abdominal section has been well said to be of as much value as a post-mortem examination; I would say it is more valuable, for we have the recent and exact clinical record side by side with the morbid appearances.

We all know that, in its healthy state, the ovary is just like the kidney—it is an organ of the existence of which the owner is profoundly ignorant. Unless it becomes diseased, it gives no sensations which indicate its existence. But, when diseased, no organ of the body gives such discomfort; and its diseases are often fatal, this result being by no means confined to cystoma.

Acute inflammation of the ovaries is often fatal; and, when not fatal, it generally leads to a state which makes life-long misery. Though I have seen cases in which no history of an acute stage could be obtained, yet, like the same disease in other organs, chronic inflammation of the ovaries generally begins in the acute form.

The origin of the acute disease is various. It may be in a simple chill, in a hæmatocele, in an attack of gonorrhœa, in some exanthematic fever, or in miscarriage or child-bed. The last two sources are by far the most common, and they present two specific varieties of the disease—interstitial oöphoritis and peri-oöphoritis.

Many of the cases of acute oöphoritis undoubtedly recover, and leave no mischief behind; but, in others, the perma-

nent mischief gives rise to suffering which to men is fortunately inappreciable. Most patients will fix a date, from which they have never known what it is to be well. A woman who has had acute exanthematic oöphoritis, with permanent mischief, will say that, since she had the small-pox, scarlet fever, or acute rheumatism, she has never had her periods as she used to have them. For a time, they were more profuse than before; then they became scanty and painful, the pain increasing as time went on, lasting a week, or even two or three weeks, in every month, rendering her utterly miserable, and being relieved by nothing but narcotics. We examine the pelvis, and find, perhaps, nothing at all. We give her iron and tonics, and all sorts of drugs, and she is no better. She goes to one specialist, and he divides her cervix or amputates it, without relief; to another, who puts in a galvanic stem; to another, who applies some useless pessary; and so on, all in vain. If she marry, she does not become pregnant. If she be in the better ranks of life, rest and luxury, with constant change of scene, make her life endurable; but, if she be the wife of an artisan, her lot is one long unhappiness till the climacteric period is passed; and, during that period of trial, many of these women become drunkards.

Cases of chronic disease arising from acute peri-oöphoritis give usually more specific indications, at least to one accustomed to pelvic examinations. Suppose that it has arisen in some attack during the puerperal month, the patient will say that she was ill with "inflammation of the bowels," and was a long time in getting about; that she has never been pregnant since, and is hardly ever free from pain. The majority of these cases occur in primiparous women; and therefore the first feature in the case to

be noticed is often that the patient has had one child soon after marriage and has never again become pregnant. If the patient be living a married life and bearing children, that alone is proof that she is not the victim of this disease, for it uniformly unsexes the sufferer as far as maternity is concerned. It also unsexes its victims for marital life in all severe cases, for they cannot endure it; and in the milder cases they cannot get well, as long as they have to submit to it.

As far as general symptoms are concerned, they are rarely free from pain; and this is generally intensified during the menstrual week, for the reason that the tubes are always involved. In most of the cases, the tubes are chiefly at fault; for I often find the ovaries cystic or shrivelled, so as to be of little account in explaining the symptoms. There is always pain in the left side in the groin; for, if one ovary be affected, it is sure to be the left. In the exanthematic cases, we have to trust almost entirely to the story of the patient as to subjective symptoms; and therefore, in this class of cases, mistakes will be made until we arrive at a more perfect method of diagnosis. In the second class of cases, however, the objective conditions are easily recognized by the practiced finger. A fixed and tender mass, composed of the enlarged and probably adherent ovary, or of the occluded and distended tube, will be felt on one or both sides of the uterus through the vaginal *cul-de-sac*; and the peculiar sickening pain felt by the patient when the mass is touched will afford conclusive proof as to its nature.

What is to be done to relieve such cases? The general principles of treatment are those applicable to all such conditions, in whatever part of the body they are met with. The first of all is rest; but, unfortunately, we cannot rest

the ovaries or the Fallopian tubes. The former will go on trying to fulfil their function of ovulation; and every month, or oftener, the inflamed organs are temporarily congested by the occurrence of menstruation. Much may be done, however, by absolute rest in bed for the whole menstrual week, and absolute abstinence from intercourse. It is very rare, however, that we can persuade patients to carry out this regimen long enough; and hospital patients will not attend to it at all—indeed, they cannot. Counter-irritation by blisters or setons is also to be tried. The only drugs of the slightest use are bromide of potassium and ergot.

After a persistent trial of these without benefit, there remains for consideration the question of removal of the diseased organs—a proceeding which is based on the soundest and most completely accepted rules of surgery. Let us take a perfectly parallel case. From some injury or gonorrhœal affection, an eye becomes acutely inflamed, and the acute process is followed by intractable chronic inflammation of the structures of the globe—a matter of every day occurrence. The ophthalmic surgeon removes the diseased organ, to save the patient's discomfort; perhaps the sight of the other eye, perhaps his life. He mutilates the patient most seriously in that part of the body where mutilation is most dreaded. He removes a diseased and useless structure. We remove inflamed and useless ovaries and tubes to relieve suffering, in some cases, to save life; and we do not mutilate our patients half so seriously as is done in the removal of an eye. The removal of a diseased eye often fails to save the other, and is then an useless operation. Removal of a cancerous eyeball is always an useless operation, for the disease always returns.

Removal of the inflamed uterine appendages may yet turn out to be a failure for some cases; but it never can be so bad as the removal of an eyeball for cancer; and, in the hands of experienced operators, the operations have quite an equal risk. Besides this, the operation for the removal of the uterine appendages is as yet in its infancy; we have very much to learn about it; yet, in spite of this, in my hands, of thirty-five cases performed for chronic inflammation, there has only been one death, or a mortality of 2.85 per cent. — a mortality which, I have some reason to believe, is less than that of excision of the eyeball. This one death was due to causes entirely preventable, and ought not to have occurred. The operation is justified by its primary success; and my belief is that my mortality, as my experience grows, will not be more than one or two per cent.

Against the operation, various *a priori* arguments have been brought. The first of these is, that it unsexes the patient. This is a perfectly needless argument, because the disease for which the operation was done has already accomplished this, as it has rendered her barren, and has made sexual intercourse a burden which she ought not to be called upon to bear. It has been said that removal of the uterine appendages destroys sexual desire; but the uniform testimony of such patients as have given evidence is that it has no such effect. But, suppose it did, what nature can any man have who would refuse to his wife relief from suffering, because it would interfere with the gratification of his lust? I am surprised that such an argument has been seriously advanced.

It has further been alleged that useless operations will be performed. Until our powers are perfect this is very likely. But of what operation in surge-

ry can this be denied? Have we not heard of lithotomies being performed where there was no stone — of amputations carried out where there was no disease in the joint? How many thousands of people have been cut for squint, when what they wanted was a pair of proper lenses?

As a matter of fact, I have found that the mere serious discussion of the operation with a humbugging patient will lead to a diagnosis. If her sufferings be real, she will jump at the chance of relief; if they be not, she declines to take the risk of the operation.

But such an operation as this demands the justification of ultimate success; and here we are on the most difficult ground. The most recent summary of cases is to be found in the second volume of Agnew's Surgery, just published, in which 171 cases are tabulated, the work of forty operators, with a mortality of 19 per cent. This is quite a satisfactory explanation of the opposition with which the operation has been met. I should long since have condemned the proceeding, and have discontinued my practice, if my mortality had been ten per cent. In fact, I did cease to operate for five years, because my mortality was 20 per cent. Of the forty operations in this table, there are only three who have operated on fifteen or more cases for all causes, not only chronic oöphoritis. These are:

| | | | | |
|---------------|-------|------|-------|---------|
| Hegar..... | 42 | | 7 | deaths. |
| Battey..... | 15 | | 3 | " |
| Lawson Tait.. | 30 | | 4 | " |
| | <hr/> | | <hr/> | |
| | 87 | | 14 | |

Or 16.6 per cent.

Increased experience, therefore, brings better primary results; and this is more than ever visible, if my whole experience is taken of seventy-five cases with only six deaths, or 8 per cent. In

my recent experience of 61 cases, there have been only 3 deaths, or 5 per cent; and confining it to the cases of chronic oöphoritis of 35 cases, there is only one death, or 2.85 per cent. It is clearly, therefore, an operation which can be justified by its primary success only in the hands of a surgeon who has large and constant practice in abdominal surgery; and when it is done by a large number of operators in twos and threes, it can only meet with speedy and well-marked condemnation.

Precisely the same kind of argument applies to its secondary results, which, in the hands of inexperienced operators, are admittedly bad. For my own results so far, I have abundant cause for satisfaction; some of my cases are yet incompletely relieved, but by far the majority of them are absolutely cured. The first patient from whom I removed an ovary for pain nine years and a half ago, was completely relieved of her symptoms, and she remains so to this day.

Subinvolution of the Uterus, its Causes, its relation to Uterine Disease, and its Preventive Treatment.

The discussion before the British Medical Society, on this subject, was opened by Dr. JOHN WILLIAMS, of London, who first defined involution as a process of fatty degeneration which began in the uterus about the fourth day after labor—not later than the eighth—and was completed in about four weeks; a process by which the organ was restored to its natural condition. Clinically, involution consisted in the reduction of the volume of the puerperal uterus to the size of the unimpregnated organ.

Reference was then made to the various ways of measuring the organ after parturition. Concerning Sinclair's method by catheterization, he thought

it liable to serious errors during the first ten days following delivery.

After the uterus had sunk into the pelvis, bi-manual manipulation combined with catheterization was the only method which gave reliable results.

The average period at which he had found the fundus within the pelvis was the twelfth day, and he assumed, for the purposes of his paper, that the uterus has undergone normal involution on the twelfth day, although the assumption would lead to some errors, because the settling of the organ into the pelvis was not positive evidence of the non-existence of subinvolution.

THE CAUSES OF SUBINVOLUTION had been said to be general debility, advanced age (bearing children late in menstrual life), multipara, premature delivery, protracted labor, post-partum hemorrhage, retention of portions of the placenta and membranes, laceration of the perineum, bruising and laceration of the cervix uteri, pelvic inflammation, too early exertion or over-exertion, displacements of the uterus, and non-suckling. General weakness must be expected to exert an influence.

Multiparity had been said to cause subinvolution, but observation seemed to show otherwise. Premature labor had come under his observation too infrequently to enable him to draw any conclusion.

The effect of protracted labor had been differently estimated by different observers.

Lacerations of the perineum played an important part as a cause of subinvolution.

It did not appear from his analysis of one hundred and twenty-six cases that laceration of the cervix affected the process of subinvolution.

Pelvic inflammation retarded involution.

Too early exertion had been maintained, with good reason, as a cause of subinvolution. Special reference was then made to the views of Dr. Goodell, of Philadelphia, who advocated getting the patient out of bed on the fourth or fifth day. Dr. Williams had not ventured to follow the method, and, therefore, had no data upon it. The opposite method, however, had been used, and with equally satisfactory results, and with the avoidance, as it seemed to him, of serious dangers.

The influence of nursing had been usually held to be highly favorable to involution.

In making a *résumé* of the causes, Dr. Williams put down general debility (?), multiparity, and advanced age (?), post-partum hemorrhage, retention of portions of placenta and membranes, laceration of the perineum, and pelvic inflammations.

The *results* of subinvolution were hemorrhage, dysmenorrhœa, prolapsus.

The *treatment* consisted in the removal or prevention of the cause. Some were not removable, but post-partum hemorrhage, laceration of the perineum, pelvic inflammations, and retention of portions of the placenta and membranes, could in a great degree, be removed or prevented. Wounds of the perineum should be closed *at once*.

He did not think that *uterine* drainage was improved by the sitting posture, although drainage of the vagina was made better by it. The removal, however, of the discharges from the uterus and vagina was one of the chief questions in the treatment of the puerperal state. Vaginal injections should be commenced immediately after delivery, and repeated twice daily, at least, and should be abundant, hot, and contain a disinfectant. They should be abundant to insure absolute cleanliness, and the temperature should be 100° to 115° F.

Prevention meant three things: (1) emptying the uterus, (2) securing a well contracted uterus, and (3) absence of fever. No better means for securing the second and third objects could be employed than hot disinfectant vaginal injections and closing wounds of the perineum.—*Med. Record*.

Steatomatous Tumors Obstructing Labor.

In the *Virginia Medical Monthly*, Dr. E. N. CHAPMAN relates some instructive cases, in which steatomatous tumors so interfered with the free passage of the child as to constitute serious impediments to natural labor. Examination in these cases revealed a growth springing from the promontory of the sacrum and the adjacent parts, occupying two-thirds of the superior strait, extending into the excavation and terminating in a prominent globular mass the size of a goose's egg. The os uteri was well dilated, and the child's head rested upon the symphysis pubis and against the anterior face of the tumor. A trocar was introduced into the tumor, and, upon withdrawing it, nothing flowed from the canula, and yet its point moved freely in every direction, showing that a cavity of some sort had been reached. Being laid open by a bistoury, a brain-like substance began to exude. This being turned out by the finger, the tumor collapsed, the child's head dropped into the excavation, and the labor was terminated at once by the forceps. There was no unusual hemorrhage then or afterwards, and the empty walls of the tumor, which had contained a pint, at least, of steatomatous matter, hung loosely from the posterior third of the pelvic brim. Peritonitis subsequently set in and the patient died on the sixth day. The other cases were similar to this one in all essential particulars. In other cases reported the patients made good recoveries.—*Med. and Surg. Reporter*.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Clinical Observations on Cystitis in Women.

Prof. A. J. C. SKENE, M.D. (Proceedings of the Kings County Medical Society).

These observations are presented for the purpose of adding to our literature some new facts regarding the treatment of cystitis.

Case I.—The patient was under my care from November 9, 1869, to February 10, 1870, while suffering from a cystitis, which began after one of her confinements. She remained under my care for only a short time, circumstances calling her back to her home in the northern part of this State. At that time she had a well marked cystitis of the purulent variety. She was treated in the ordinary way by injections with some benefit. I also employed drainage part of the time, by introducing a catheter in the evening and letting it remain all night. This gave her great relief and permitted her to sleep—a blessing which she had not enjoyed for several years. She was improving in her general health, although her local disease remained about the same, or at least only a little improved. She expected to return for further treatment, but her husband becoming paralyzed, she was obliged to give up the care of herself to look after her family. From that time up to this last July, she continued to suffer tortures during the day, while she was obliged to be up and around attending to her household duties. At night she obtained relief from wearing the catheter, which she contin-

ued to use ever since she was taught to do so, twelve years ago. Her sufferings were almost beyond description, but having an iron constitution and extraordinary will power, she managed to live until this summer. During June and July last she failed more rapidly. Having heard of dilatation of the urethra as a cure for cystitis, she urged her physician to try that operation. He did so about the end of last July and repeated the operation one week later. The only effect of this treatment (as stated in the notes of her history, which I obtained) was to reduce the number of evacuations from 160 to 100 a day. Her physician then injected her bladder in the hope of relieving the inflammation and also overcoming the contraction, which was very marked. Immediately after the injection she was seized with violent abdominal pains, and rapidly developed a peritonitis which proved fatal on the second day.

On post-mortem it was found that the bladder was adherent to all the viscera around it; the result, no doubt, of a former pericystitis. Upon the posterior wall of the bladder, and directly opposite the urethra, there was a nipple-like projection outwards, with an opening at its apex large enough to admit a lead pencil. This protuberance had been produced by the long use of the hard catheter. The instrument had worn through the inner walls of the bladder, until the parts had become less resistant; it then pushed the remaining muscular tissue and peritoneum outward, and formed the nipple-like projection. At the time of the fatal attack, the catheter had made way through all the coats of

the bladder except the thickened peritoneum. The rupture of the peritoneum was caused by the injection. That was the belief of the physician in attendance, and the history points definitely to the same conclusion. The bladder was firmly contracted and indistensible; its retaining capacity did not exceed half an ounce. The muscular wall was over half an inch thick; the mucous membrane was all destroyed by the inflammation.

Case II.—Is that of a lady possessing remarkably good organization. Married and had one child. Her age was thirty when her illness began. While riding horseback she was thrown off and sustained some apparently slight injuries. Her health, up to this time, had been very good, but from the time of her accident, September, 1878, she had symptoms of cystitis. She was residing in the far West at the time of the accident, and as I did not see her for several years after, and have not been able to correspond with the surgeon who then attended her, I do not know the relation which the injury sustained at that time bears to the development of the cystitis. I only know that the one followed the other immediately. The cystitis persisted, and her constitutional symptoms increased from time to time. She then returned from the West to New England to be under the care of her father, who is a physician of known ability and large experience. He gave her every attention and placed her in the care of a neighboring physician who has a high reputation as a gynecologist. Without giving full details of her treatment at that time, I may fairly state, upon information received from her father and her physician, that all the recognized means of treatment were tried, including complete dilatation of the urethra on two occasions. The cystitis was not at all re-

lieved by the treatment, and her constitutional symptoms increased continuously until she became confined to bed. Having a highly sensitive nervous system, she suffered greatly from want of sleep, and the constant pain of cystic tenesmus. I first saw her in consultation about a year from the time when she was first taken ill. It was then that this much of her history was obtained. She continued under treatment for six months longer, and at the end of that time she consulted one of the best known and most worthy authorities in New York. He advised cystotomy and drainage for six months or longer, stating at the same time that, in view of the failure of her former treatment to give relief, there was nothing else left to be done. She declined to submit to the operation at that time. Her father then sent her to me about two and a half years ago. At that time she was obliged to urinate about every hour, night and day. She suffered from constant tenesmus, and her nervous system was greatly debilitated. Dr. McCorkle examined the urine for me and found that it contained a large quantity of pus, and there was a remarkable absence of epithelial cells. The doctor's report was that the specimen was pus containing a small quantity of urine, and evidently came from a bladder which had entirely lost the upper layer of its mucous membrane. The diagnosis then made was chronic purulent cystitis. It appeared to me that the case was one which called for cystotomy, but knowing the objection of the patient to that operation, treatment was undertaken and the results soon gave some slight encouragement. The constitutional treatment was at first chiefly tonic in character, and subsequently she took saline waters, lithia waters, bromide of lithia, and finally buchu, benzoin, tar, turpentine and the

like. These last preparations, however, did not help her and were not long continued. The local treatment was first instillations of a warm solution of borax. Half an ounce was instilled at a time and repeated until from eight to twelve ounces were used at each treatment. The instillations were always made with very low pressure. As the sensitiveness of the parts diminished, the quantity used was increased up to one ounce, but never beyond that. Three months of this treatment showed improvement. There was less pain, and the patient's general health had improved considerably. About this time nitrate of silver was used, and later, sulphate of zinc, in solution of various degrees of strength, but this always caused pain. Indeed, the suffering caused by this kind of treatment was great, and the benefit which followed being very little it was given up. I then began to use instillations of an infusion of *hydrastis canadensis*, containing a small quantity of salicylate of soda, which was used to prevent decomposition of the infusion. I am now satisfied that the salicylate was of value in its effect upon the suppurating mucous membrane. The *hydrastis* was very faithfully used, first by myself, and subsequently by the patient, who made the instillations with unusual intelligence and care. The result was a gradual diminution of the pain and lessening of the frequency of urination. The pus diminished in quantity, and simultaneously young epithelial cells appeared in the urine and increased in number as the pus diminished. At the end of one year of treatment the local and constitutional symptoms had all disappeared. The urine was normal and the patient had fully recovered, excepting that she was obliged to urinate about every four hours. This was owing to contraction of the bladder. To overcome this, gradual

distention was practiced. The patient was directed to retain her urine until discomfort, not pain, was felt. Injections were used, each time distending the bladder a trifle more, always stopping short of causing pain. About two years from the time she first came under my care she was perfectly cured of the cystitis and had regained her normal retaining power. Six more months have passed and there is not the slightest evidence of any return of the former affection.

Case III.—This lady, thirty-four years of age, is married and had four children. She is said to have had retroversion of the uterus, which was held in its abnormal position by adhesions. She was treated for this displacement in the Woman's Hospital of New York, so she says, and while under treatment a cystitis was developed which has continued ever since. After leaving the hospital she became pregnant and her sufferings increased. Two years ago, when her last child was four weeks old, she consulted a physician here in Brooklyn, who advised cystotomy, and soon after he performed the operation, using the cautery. She experienced some relief from the operation, but she still suffered very acutely. Being led to hope that in time the operation would cure her, she bore her afflictions for nearly a year, when she consulted me on the 5th of September, 1881. I then found her to have the tubercular diathesis, rather well marked, but there was no apparent disease of the lungs at that time. The vesico-vaginal fistula, made by the operation, was large enough to admit the little finger, and the drainage of the bladder was quite complete. Yet, strange to say, she had constant pain in the bladder and a desire to urinate. These symptoms I found to be due to inflammation and ulceration of the urethra and bladder

below the fistula. The disease at this location caused pain and irritation, which provoked reflex action, such as that which arises from the presence of urine in the bladder, but in a much greater degree. General tonic treatment was advised, and local treatment employed to relieve the inflammation of the urethra and the neck of the bladder. Locally she improved slowly. The pain and vesicle tenesmus subsided almost wholly, but she has not yet recovered completely. My object was to cure the local disease and then close the fistula. This I shall never be able to do. While the local disease is improving she is developing phthisis pulmonalis, which precludes all thought of operating to close the fistula. The facts in this history, which I trust will be borne in mind, are, that this patient was of a tubercular organization. That cystotomy did not cure her cystitis and urethritis, nor relieve her suffering to any marked extent.

Case IV.—Six years ago I had a case of cystitis under observation, which illustrates the same facts in pathology and therapeutics as in Case III.

I shall give a very brief outline of the history, simply to show the result obtained by another method of doing the same operation. This patient was a married woman who had several children. She was of a highly nervous temperament, and came from a tubercular family. She consulted me for cystitis, the cause of which is not recorded in her history. I treated her with injections for several months without benefit. I also dilated her urethra, with the same result. In fact, I believe, she rather grew worse in place of better while under my care. Her general health failed noticeably at any rate, and she gave signs of a tubercular deposit going on in her lungs. Her friends

urged her to enter the Woman's Hospital in New York. She did so, and was under the care of Dr. Emmet, who performed cystotomy, which he did by incision and keeping the fistula open, first by his glass tube and afterwards by dilation with the finger. After the operation she had an attack of pneumonia—at least she told me this when she returned from hospital. Upon her return home I found that she had been much relieved of her most urgent symptoms by the operation. Still there was cystitis remaining, and she still had vesicle pain and tenesmus. The tubercular disease of her lungs had progressed rapidly, and that portion of her lung which was involved in the pneumonia never cleared up. Her strength rapidly failed, and she died before the cystitis subsided.

The first case illustrates one danger in using the catheter which has not been noticed heretofore, so far as I know. One would hardly suppose that the catheter, retained at night only, would perforate the walls of the bladder; still in this case it did so, and led to the fatal issue of the case. This danger no doubt lies in the use of a hard catheter, which was used. Such was the crude state of my knowledge at the time in regard to draining the bladder that I used that kind of instrument, which I have ever since known to be very objectionable. The non-vulcanized rubber catheter is the only one which should be retained for any length of time.

This case also shows the great danger of trying to distend, by injections, a bladder which has for years been contracted from cystitis. I am satisfied that this practice is exceedingly hazardous, and at the same time it is entirely ineffectual, as a rule. The danger lies in the fact that the walls of the bladder are liable to be attenuated or softened at certain points, and hence very likely

to rupture under undue pressure. Again, when the bladder refuses to distend under the normal pressure of the urine, after all traces of cystitis have disappeared, it is good evidence that the walls of the organ are hypertrophied and to a certain extent permanently contracted, or the whole organ is bound down by pericystic adhesions. Indeed, both of these conditions may be present, as in case first. It follows, then, that the only safe and sure way of distending a contracted bladder is by slow, gradual education. The patient should retain the urine as long as possible without causing suffering from acute pain, and once or twice a week a saline solution should be instilled at a pressure only a little higher than the normal pressure of the urine. The quantity used should be regulated by the feelings of the patient. As soon as she is painfully conscious of the distention the pressure should be taken off. I am quite satisfied that this method will succeed in curable cases, if the patient and surgeon will take the required time and trouble. Case second is a fair example of what I have been able to accomplish in this way.

Forcible and extreme dilatation of the urethra is advocated in the treatment of cystitis by many surgeons otherwise well informed. Within the past few years the medical journals have contained the histories of many cases of cystitis said to have been cured by this operation. This is all quite erroneous. Generally, cystitis can no more be cured by dilating the urethra, than could a gastritis be cured by dilating the sphincter ani. It is a fact that if the urethra be destroyed by over-distention, incontinence will follow and the perfect drainage of the bladder will cure the inflammation; but verily the cure is worse than the disease. I am sure that the mistake in regard to the value of this

operation in cystitis comes from its having been practiced in cases of acute cystitis which would have ended in recovery without any surgical treatment, and again in cases of inflammation of the upper third of the urethra which have been mistaken for cystitis. On the one hand the operation gets the credit of curing a disease which cured itself, and on the other of curing a disease which did not exist. It will be observed that in cases first and second the urethra was dilated with no benefit, and to these I could add many others which were treated in the same way with a like result.

Cystotomy, as a means of treating cystitis, is of great importance. There is, however, still some doubt in regard to its relative value and the indications demanding operation. That its merits have been over-estimated appears from the prevailing opinion that cystotomy will immediately relieve the pain and tenesmus and cure the cystitis in the course of time. This is not by any means true as a rule. Cases third and fourth were neither cured nor fully relieved from suffering by the operation. The same was the result in some cases operated on by myself. In cases where the inflammation is confined to the upper portion of the bladder, and limited to the mucous membrane, cystotomy will give relief and in time cure the cystitis; but if the neck of the bladder is affected, and especially if the patient is tubercular, the operation will not accomplish either of these results.

It will be observed that the cases which show the best results after cystotomy are, like case second, the ones which yield to local treatment by instillations. Cystotomy certainly gives more prompt relief; but when we take into account the operation, the discomfort of the patient from incontinence,

and the second operation to close the fistula, the tax upon the surgeon and the patient comes nearly to equaling that of the other method of treatment.

From all this I am inclined to believe that cystotomy, great as its value is in the treatment of cystitis, will become more circumscribed.

The Blunt Curette in the Treatment of Some Forms of Uterine Disease.

Dr. CLINTON CUSHING, (*Western Lancet*):

Having used the blunt curette in a considerable number of cases of uterine diseases within the past three years, I take this opportunity of calling the attention of the members to some of its advantages.

The instrument that I have used consists of a shank of copper wire fastened securely into an ebony handle, and tapering gradually from the handle until about the size of an ordinary darning needle, when it widens out into a flat concave, spoon-shaped extremity, with a dull edge upon its concave border. The metal portion of the instrument is plated with nickel. It will be observed that the shank of the instrument for four inches next the spoon is very elastic, as well as being flexible, allowing it to be bent with ease into any position. The two points to which I would particularly call attention are the elasticity and flexibility of the copper shank, and the very dull edge of the curette.

The instrument is used only for curetting the cavity of the body of the uterus. The size of the curette used being governed by the size of the cervical canal, and of the uterine cavity; the smallest size of the set of three, which I show you has a spoon one-fourth of an inch in width; the next size, one-third; and the largest, one-half inch in width.

I use it in the following manner: I place the woman upon the left side, and expose the cervix with a Sim's speculum. I then seize the anterior lip of the cervix with a delicate vulsellum, which I here show you, in order to draw the uterus gently forward and to steady it. Next, I introduce a slender uterine sound to determine the direction and depth of the cavity. The shank of the curette is then bent to conform to the curve of the canal, and is introduced carefully to the fundus, and the whole cavity gently but firmly curetted.

It is impossible with this instrument to use any considerable force, for the copper wire is too pliable, and the curette is too dull, to do more than remove softened and diseased tissues, as can be easily demonstrated by drawing the instrument firmly over the mucous membrane of the mouth.

In the class of cases where the use of the curette is indicated, the cervix is usually sufficiently patulous to admit of the introduction of the curette without difficulty, but whenever necessary, I use an ordinary two-bladed uterine dilator, and enlarge the canal sufficiently to proceed with the operation: when needed the dilatation is but a moment's work, and is attended with but little pain.

The operation, although not painless, is seldom attended with sufficient suffering to require an anæsthetic; and if I may judge from my own somewhat extensive experience, and by the recorded statements of those who habitually use this instrument, its use is singularly free from danger, when used in appropriate cases and in a proper manner.

The contra-indications for its use are any acute or sub-acute inflammation of the pelvic areolar tissue, or of the pelvic peritoneum.

Admitting that its use is attended with so little danger, I still must look upon

its application as an operation, and although I have occasionally resorted to it in my office without its being followed by bad results, I would advise strongly against it, and think it should be used at the house of the patient only, in order that she may be put to bed immediately afterwards, the feet kept warm, and the use of opiates and hot water vaginal injections used, if required. Indeed, in all cases I order a large hot water vaginal injection to be given after the operation, and insist that the patient remain quiet for several days thereafter.

As a means of diagnosis the blunt curette is often of value.

In cases where there is a discharge of blood or mucus from the cavity of the uterus, and the question is to be determined as to the existence of cancer or sarcoma, or of fungosities of the mucous membrane of a benign nature, we are able, by removing from the cavity some small portions of tissue, and submitting them to examination under the microscope, to determine the nature of the case.

Certainly this means of determining the nature of disease existing in the uterine cavity is much more satisfactory and reliable than the method formerly adopted of dilating the cervix with tents and endeavoring to introduce the finger up to the fundus; this last proceeding being only demanded to diagnose the existence of a small fibroid growth projecting into the uterine cavity.

In the treatment of menorrhagia, the blunt curette often proves of great service, especially in those cases where there is enlargement of the uterus, and the menorrhagia dates from the occurrence of an abortion, or is apparently due to sub-involution following child-bearing. In these cases we find that the os is patulous, the menstruation is too frequent or too profuse, the

quality of blood is poor from the repeated losses, and we are unable to control the hemorrhages by medical treatment or by astringents applied topically. A uterine sound passed carefully into the uterus at any time during the month provokes a discharge of blood, and causes a sense of pain or discomfort to the patient. In this condition I have found no plan of treatment so universally satisfactory as the use of the curette in the manner already described, and afterwards painting the cavity freely with the saturated tincture of iodine. This treatment can be repeated at the end of a month, if required. No hemorrhage attends or follows the operation.

In order to be certain what I remove from the uterus I resort to the following plan: With a sponge held in the grasp of a sponge-holder, I remove all the blood and debris that escapes from the uterus into the vagina, and put it into a wash-basin of water, and then by thorough washing remove all the clots and blood, and by changing the water several times have left in the bottom of the basin the shreds of tissue, fungosities and bits of softened and diseased mucous membrane. This, in some cases, amounts to only a few fragments; in others to a teaspoonful.

Let it not be supposed from what I have said that this diseased or fungus condition of the mucous membrane exists only in those who have been impregnated; any cause that produces and keeps up a congestion or enlargement of the uterus is liable to induce a hypertrophy of its inner lining with its increased secretion and enlarged blood vessels with thinned walls.

As examples of this, I would mention those cases of displacement of the uterus downward or backward, the existence of fibroid growths in the walls of

the uterus; the habit of wearing tight corsets, thus interfering with the return circulation; the residence in a malarious region where the liver and spleen are enlarged and the venous circulation sluggish. All these act as factors in producing a passive congestion of the pelvic and uterine tissues, thus laying the foundation for the diseases in question, for the cure of which the curette may serve as a not unimportant element of the general plan.

I do not wish to be understood as advocating the use of the curette in these cases as a specific, to the exclusion of other methods; on the contrary, I admire its use in conjunction with those means, both medical and hygienic, which experience has shown to be of value.

The hemorrhage from the uterus caused by the development of fibroid tumors in its walls comes from the blood vessels of the mucous membrane overlying the growth, and probably the hemorrhage is due to rupture of these blood vessels, whose walls have become thinned from over distension.

As a means of controlling the bleeding, I have found that the passage of the blunt curette firmly and thoroughly over the entire uterine cavity, and afterwards sponging the cavity with hot water, and leaving in the uterus a pledget of cotton moistened with the saturated tincture of iodine, to be followed by good results. This of course is only a temporary expedient, for the real cause is not removed; nevertheless, it is one that may serve as well in time of need. It probably acts by breaking up and destroying the superficial veins from which the oozing takes place.

In chronic endometritis, we find, in common with chronic inflammation of mucous membranes elsewhere in the body, the endometrium thickened and

softened, with increased secretion, and with enlarged and dilated vessels; that the mucous glands are enlarged, and the surface studded with granulations. In this condition, I would advise, as a preparatory measure, before making any local applications to the endometrium, that the blunt curette be used, and, as far as possible, all the softened and diseased mucous membrane be removed, together with its enlarged glands, small condylomata, and enlarged vessels.

In hyperplasia of the body of the uterus, whether following abortion or confinement at full term, constituting what is known as sub-involution, or whether it arise from long-continued congestion of the uterus, from displacement or from other causes, the lining membrane is frequently involved and in an unhealthy condition, shown by derangement of menstruation, increased mucus, or muco-purulent discharge.

In this condition, in conjunction with other means, the use of the curette to the uterine cavity is followed by marked improvement of the symptoms, and a lessening of the size of the uterus.

In concluding what I have to say upon this subject, I would call attention again to the importance of never undertaking this operation when there exists any acute or sub-acute inflammation about the pelvic peritoneum or the pelvic connective tissue, for, as all are aware, local interference of any kind is badly tolerated in such cases, and is commonly followed by an aggravation of all the symptoms, and he who uses the curette in the manner I have described will be the least likely to witness ill effects who most carefully eliminates those cases where any kind of intra uterine medication is contra-indicated.

Sterility.

Dr. ARTHUR B. EDIS, assistant obstetric physician to the Middlesex Hospital, etc., is the author of a paper, in the *British Medical Journal*, on sterility. "It is somewhat surprising," he says, "that more notice has not been taken, in our modern works on gynecology, of the frequency in which married women miscarry during the first few months of their matrimonial existence, or become mothers within the first twelve months, and yet never afterwards conceive."

Conception can and does occur, showing that the reproductive organs are thus far correct, but before gestation has been completed, miscarriage occurs, followed by leucorrhea, back-ache, menorrhagia, etc. In some cases the first pregnancy is completed to be followed by the same distressing symptoms narrated above, and partly due to her own imprudence, partly to a lack of care, and partly to a vitiated constitution.

"Now, what is the interpretation of this? In many of these cases the patient has become infected with latent gonorrhœa, as pointed out by Dr. Emil Noeggerath, and the whole genito-urinary tract becomes involved in the specific inflammatory process—chronic endometritis and ovaritis of a very intractable form resulting."

"In many other cases of acquired sterility the uterus remains for many months following parturition in a state of subinvolution."

Though by no means so frequent as the latter, superinvolution may result; this is generally caused by some inflammatory action following parturition and involving among other organs one or both ovaries. The presence of tumors in the uterus, especially intra-mural fibroids, tend greatly towards the production of sterility.

Flexions of the uterus, after induction, promptly recur, though full term pregnancy has intervened.

"It should be considered a part of every medical man's duty who attends a patient in labor to examine her carefully at the end of a month or six weeks afterwards, in order to determine whether she has incurred more than the ordinary penalties of parturition, and whether she is in a fair way to recover her former physiological condition."

Among the means mentioned for treatment are puncturing, or scarifying, the inflamed cervix, the use of hot water vaginal injections, tampons soaked in glycerine, etc. Nitric acid may be applied to the granular mucous lining of the cervix, or the operation of tracheloraphy, if the cervix is lacerated, may be performed.

The author advises, for the reduction of displacements, the prone or genupectoral positions, relying upon the careful adjustment of pessaries to overcome adhesions rather than force in tearing them away.

The author has not mentioned the important fact that, along with the treatment spoken of, sexual repose is beneficial. To suffer this function to be indulged in (and in the conditions which the author has described the sexual appetite is generally greatly exaggerated) would be equivalent to satisfying the morbid cravings of a dyspeptic, and could result only in harm. How much easier such long and tedious cases can be managed when away from home must appear to every thoughtful mind. But, as all will agree, the difficult matter is to enforce this precaution. Any amount of advice, as delicate as the subject is to talk about, will do no good, and the object can seldom be accomplished short of actual separation of the husband and wife.—*Obstetric Gazette.*

External Follicular Vulvitis.

The following is a *résumé* of the conclusions arrived at by Drs. GONGUENHEIM and SOYER in the course of an article with the above title, published in the *Annales de Dermatologie et de Syphilographie* for April, 1882. The varieties of follicular vulvitis are: 1, simple acute follicular inflammation; 2, acne due to different causes; 3, syphilitic acne; 4, syphilitic follicular inflammation. Simple follicular vulvitis is rare. It terminates most frequently in furuncular inflammation. The acne due to causes other than syphilis, does not differ in any way from the same affection when developed in other regions. Syphilitic acne does not differ from the preceding variety. It may not appear in a pustular form, or, having become pustular, may ulcerate. Several ulcerated follicles may unite and simulate a simple chancre. The syphilitic follicular inflammation is an interesting but often misinterpreted form of simple chancre, which it usually accompanies, and to which it is most frequently secondary. This variety of chancre develops very slowly; it may become abortive, or may ulcerate and assume the appearance of a true chancre. The pus from syphilitic folliculitis is quite as virulent as that of a simple chancre. The differential diagnosis of these various affections is, generally, easy. Simple acute folliculitis is distinguished by the rapidity and severity of its course. The nature of the various kinds of acne is determined by the concomitant signs of the diathesis or disease producing them. Syphilitic follicular inflammation is distinguished from simple acute folliculitis by its limited extent, by its tendency to rapid ulceration, and to the invasion of adjoining follicles, and by the presence of a chancre in its neighborhood. In

doubtful cases inoculation settles the question. The morbid anatomy of these varieties of follicular inflammation is not different from that of folliculitis in other localities. Topical treatment is alone necessary for simple and syphilitic follicular vulvitis. Internal and external treatment must be combined in cases of chronic follicular inflammation of, or folliculitis dependent upon a diathesis.—*Med. Review.*

New Treatment for Vaginitis.

M. TERRILLON proposes a method of treatment which consists essentially in the introduction into the vagina of the following ointment: \mathcal{R} Ac. tannic, 50 grams; amyli, 150 grams; ung. petrolei, 150 grams. M. This ointment is placed in a sort of speculum, so arranged that the ointment can be forced out as the instrument is withdrawn from the vagina. If the vulvar opening is large a small tampon of cotton may be introduced. Generally from fifteen to twenty grams of the unguent is sufficient at one application, and it need not be repeated for seven or eight days.—*Med. & Surg. Reporter.*

Sounding the Female Ureters.

Dr. PAWLICK finds that when a woman is placed in the knee-elbow position, and the posterior vaginal wall is drawn upwards and compressing the rectum by means of a Sims' speculum, the trigonum vesicæ and the entrance places of the ureters are plainly visible. It is then not difficult, with a specially designed catheter, to sound the ureters. He demonstrated his proposition upon two women whom he brought with him, and was able, in both cases, in a short time, to sound the ureters with perfect safety.—*Philad. Med. News.*

DISEASES OF CHILDREN.

Cerebral Irritation in Children.

The *Annales et Bulletin de la Société de Médecine de Gand*, for May, 1882, quotes from the *Praticien* an article by Dr. J. SIMON, bearing the above title. Dr. Simon lays stress upon the fact that this form of cerebral irritation differs very markedly from the affection as seen in adults. He defines it as a slowly progressing neuropathic condition, unaccompanied by any organic lesion, beginning in early infancy; and throughout its course entirely free from any accompanying febrile action. It is not incurable, but, unless subjected, almost from the start, to a treatment both careful and systematic, and, above all, persistent, it will lead inevitably either to sclerosis of the brain or to epilepsy, meningitis, etc.

The child affected with cerebral irritation is one in whom nervous reaction is exaggerated, and in whom over-active cerebral circulation gives rise to a condition of irregularly disseminated congestion. Such a child is commonly the offspring of parents having the nervous diathesis, the subjects, perhaps, of some distinct neurosis, and not infrequently the victims of chronic alcoholism. Syphilis in the parents is another predisposing cause. As immediate exciting causes, we have exposure of the child to the excitements of society life, especially as it exists in large cities, and also the use of tea, coffee, or wine.

Beginning even in the infant at the breast, cerebral irritation may persist up to the fifth or sixth year of life. At this age it either disappears or undergoes a modification of its character, as it now shows itself under the form of epilepsy, sclerosis, meningitis, etc. The symptoms of cerebral irritation in the child

do not lead the parents to suspect either existing or threatened disease. By them the child is merely regarded as wilful, capricious, nervous, excitable, restless, etc. He is subject to night terrors, to sleeplessness, is easily agitated by day, and shows fickleness in his moods, while a general lack of harmony is observable in his actions. The cutaneous sensibility is disordered. To a careless observer many of the symptoms would seem to point to the approaching onset of some acute inflammatory disorder, such as pneumonia, scarlatina, or typhoid fever, but there is never any rise of temperature, neither is there any delirium. Again, there are no persisting epileptiform phenomena, no paralytic attacks, no motor disturbances, such as succeed the congestive attacks of cerebritis or cerebral sclerosis. This condition is, as before stated, a frequent sequela to the purely irritative morbid condition mentioned, and unlike the latter, is accompanied by organic lesions.

The prognosis of cerebral irritation in children is necessarily serious. Nevertheless, not fatal, as serious consequences may be averted by rigorous and persistent treatment. For the success of such treatment the physician must have entire control of the case. While constantly on his guard against the ever threatening termination of the condition in cerebral sclerosis, the physician must be prepared for the occurrence of eclamptic seizures. They are, indeed, very easily provoked, and, if frequently repeated, predispose in their turn to cerebral congestions. A complete cure, however, is not to be despaired of, even though, as the result of such attacks, the patient be brought, as it were, upon the very verge of sclerosis. Symptoms due to attacks of cerebral congestion will sometimes be more marked upon one side of the body than upon the

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M. TERRILON proposes a method of treatment which consists essentially in the introduction into the vagina of the following ointment : \mathcal{R} Ac. tannic, 50 grams ; amyli, 150 grams ; ung. petrolei, 150 grams. M. This ointment is placed in a sort of speculum, so arranged that the ointment can be forced out as the instrument is withdrawn from the vagina. If the vulvar opening is large a small tampon of cotton may be introduced. Generally from fifteen to twenty grams of the unguent is sufficient at one application, and it need not be repeated for seven or eight days.—*Med. & Surg. Reporter.*

Sounding the Female Ureters.

Dr. PAWLICK finds that when a woman is placed in the knee-elbow position, and the posterior vaginal wall is drawn upwards and compressing the rectum by means of a Sims' speculum, the trigonum vesicæ and the entrance places of the ureters are plainly visible. It is then not difficult, with a specially designed catheter, to sound the ureters. He demonstrated his proposition upon two women whom he brought with him, and was able, in both cases, in a short time, to sound the ureters with perfect safety.—*Philad. Med. News.*

DISEASES OF CHILDREN.

Cerebral Irritation in Children.

The *Annales et Bulletin de la Société de Médecine de Gand*, for May, 1882, quotes from the *Praticien* an article by Dr. J. SIMON, bearing the above title. Dr. Simon lays stress upon the fact that this form of cerebral irritation differs very markedly from the affection as seen in adults. He defines it as a slowly progressing neuropathic condition, unaccompanied by any organic lesion, beginning in early infancy; and throughout its course entirely free from any accompanying febrile action. It is not incurable, but, unless subjected, almost from the start, to a treatment both careful and systematic, and, above all, persistent, it will lead inevitably either to sclerosis of the brain or to epilepsy, meningitis, etc.

The child affected with cerebral irritation is one in whom nervous reaction is exaggerated, and in whom over-active cerebral circulation gives rise to a condition of irregularly disseminated congestion. Such a child is commonly the offspring of parents having the nervous diathesis, the subjects, perhaps, of some distinct neurosis, and not infrequently the victims of chronic alcoholism. Syphilis in the parents is another predisposing cause. As immediate exciting causes, we have exposure of the child to the excitements of society life, especially as it exists in large cities, and also the use of tea, coffee, or wine.

Beginning even in the infant at the breast, cerebral irritation may persist up to the fifth or sixth year of life. At this age it either disappears or undergoes a modification of its character, as it now shows itself under the form of epilepsy, sclerosis, meningitis, etc. The symptoms of cerebral irritation in the child

do not lead the parents to suspect either existing or threatened disease. By them the child is merely regarded as wilful, capricious, nervous, excitable, restless, etc. He is subject to night terrors, to sleeplessness, is easily agitated by day, and shows fickleness in his moods, while a general lack of harmony is observable in his actions. The cutaneous sensibility is disordered. To a careless observer many of the symptoms would seem to point to the approaching onset of some acute inflammatory disorder, such as pneumonia, scarlatina, or typhoid fever, but there is never any rise of temperature, neither is there any delirium. Again, there are no persisting epileptiform phenomena, no paralytic attacks, no motor disturbances, such as succeed the congestive attacks of cerebritis or cerebral sclerosis. This condition is, as before stated, a frequent sequela to the purely irritative morbid condition mentioned, and unlike the latter, is accompanied by organic lesions.

The prognosis of cerebral irritation in children is necessarily serious. Nevertheless, not fatal, as serious consequences may be averted by rigorous and persistent treatment. For the success of such treatment the physician must have entire control of the case. While constantly on his guard against the ever threatening termination of the condition in cerebral sclerosis, the physician must be prepared for the occurrence of eclamptic seizures. They are, indeed, very easily provoked, and, if frequently repeated, predispose in their turn to cerebral congestions. A complete cure, however, is not to be despaired of, even though, as the result of such attacks, the patient be brought, as it were, upon the very verge of sclerosis. Symptoms due to attacks of cerebral congestion will sometimes be more marked upon one side of the body than upon the

other. This may be true of a sense of formication, or, perhaps, we may find a slight degree of weakness in a single limb, or it may be in the upper and lower limbs of the same side. All such phenomena being in pure cerebral irritation of children extremely transitory in their nature.

In most cases cerebral irritation quite disappears after a certain age. Nevertheless, occasionally it appears to lie dormant and ready to break out in severer cerebral symptoms on the advent of some intercurrent malady.

Treatment should be both hygienic and by drugs. As a main factor of the hygienic treatment, the child must be carefully guarded against excitement of all kinds. Among drugs, Dr. Simon has found bromide of potassium by far the most efficacious. He gives it in steadily increasing doses until a slight degree of prostration is produced. To a child of two years he administers as much as a gramme per diem at the start, dividing it into three doses, and invariably directing that it be taken before meals. This quantity he increases to a gramme and a half, and then to two grammes per diem, and continues giving the latter amount for four or five days. The dose is then progressively diminished. In no case, however, should the drug be completely suspended for any length of time. Treatment must be kept up until every nervous symptom has disappeared.

Besides potassium bromide, Dr. Simon employs mild derivatives, preferring the application of dry cups along the upper portion of the spinal column, and at points on a level with the mastoid processes, rather than the use of vesicants. Tepid baths he also recommends, as well as certain medicated baths, *i. e.*, *bains de tilleul*, *bains de valeriane*. The use of electricity or of the douche he strongly condemns, and he considers sea air ob-

jectionable. Constipation is of course, to be avoided, as tending to induce cerebral congestion, and the digestive organs must receive careful attention.—*Med. Review.*

Icterus Neonatorum.

BIRCH HIRSCHFIELD, in an article in Virchow's *Archiv*, an abstract of which appears in the London *Lancet*, gives the following as the pathology of that hitherto obscure disease: It is very difficult to avoid associating the jaundice in some way with the disturbance of the hepatic circulation on the transfer of its chief blood supply from the umbilical vein, especially when regard is had to the conspicuous congestion and œdema of the liver, well described by Weber, which occur in cases in which the circulation through the umbilical cord is interrupted before the respiratory movements, by their effect on the right heart, afford an adequate compensation. The vessels in the hilus of the liver are surrounded by a dense layer of connective tissue, which is continued into the organ along the branches of the portal vein, and in which there is venous obstruction in the liver, in consequence of hindered birth, this tissue is the seat of conspicuous œdema. A broad layer of gray pulpy tissue encloses the vessels, and is seen also around the umbilical vein in its diaphragmatic portion, and may also extend to the gall-bladder. The microscopical appearances of this tissue are those of œdema, with a more or less abundant accumulation of round cells in the interstices of the tissue. This swelling of the tissue must compress the bile-ducts obviously, and, not only under these circumstances are the bile-ducts distended, but there may be a positive difficulty in squeezing the bile out of the gall-bladder in the duodenum, and in the latter there is a manifest

deficiency of bile. In such cases, in which death occurs during the first day of life, commencing icterus may be distinctly detected, and the gradual increase of the jaundice in connection with this pathological condition, may be observed in patients in whom life continues longer, as cases reported by Birch Hirschfield demonstrate.—*Chicago Medical Journal and Examiner*.

Cod-Liver Oil in Young Children.

The *Lancet* says: If diarrhœa or vomiting be present—speaking generally, though by no means absolutely—the use of cod-liver oil internally is contra-indicated in young children; but if neither of these symptoms be present we cannot recall a more useful agent in the marasmic conditions of infancy. We cannot fix any limit of age, but we have seen infants of a month old distinctly improve while taking it, and we should have thought the enormous benefit of this agent to rickety children, both under and over twelve months old, had become a truism in medicine. Even in hereditary syphilis, although it will not take the place of gray powder, in our experience, cod-liver oil is a most valuable adjunct in treatment. Also, besides generally helping in the nutrition of a feeble infant, observant mothers often point out that the regular employment of cod-liver oil assists in overcoming the occasional difficulty of constipation.—*Med. and Surg. Reporter*.

Treatment of Infantile Diarrhœa.

This is the chief disease of infants, and the hygiene is more necessary very often than the medicines employed. Among infants at the breast, the cause of diarrhœa is as often the fault of the nursing mother as of the infant. The abuse of baths is a prime cause, being

often more injurious than beneficial, from being too prolonged, instead of a single washing of the body.

As to dentition, Dr. SIMON attributes great influence, though denied by many authors. In the simple cases, after ascertaining the cause, if possible, stop everything but the milk and give a spoonful of coffee with a little alkaline water. A tepid bath should be given each day and a starch injection; every day at each meal give a portion of the following powder:

R. Calcined magnesia, 10 grammes; prepared cream and sub. nitrate of bismuth, aa 2 grammes.

At last apply warm fomentations to the bowels.

If the diarrhœa continues and becomes catarrhal, *i. e.*, accompanied with a considerable secretion and intermitting fever, it is better to give a vomit and afterwards a portion of sub-nitrate of bismuth, 4 grammes with one drop of laudanum, to an infant under one year of age.

At the advanced stage the diarrhœa becomes sympathetic of enteritis. This is distinguished by the passages, which are green, acid and extremely irritating. The fever is persistent and the countenance indicates suffering, a sign very significant of unfavorable results.

It is now necessary to give laudanum, the true treatment of enteritis, with sub-nitrate of bismuth, a drop of the former to 60 grains of the latter, to each year of age. Paregoric can be used in the place of the laudanum—5 drops to 1 of laudanum. It ought not to be forgotten to continue the laudanum after the passages are checked, but in diminished doses. If vomiting should occur, prepared chalk and lime-water should be applied, and a small blister over the epigastric region, using the necessary precautions.

In enteritis it is often observed that membranous fragments are expelled, with violent colic, and in these cases the injections should be frequent and cathartics used. It is necessary to keep up this treatment with alkaline waters, excluding grease and indigestible articles, and hydrotherapy, when the age of the infant permits.

Chronic enteritis is extremely difficult to treat; opiates and astringents should be used and afterwards revulsives, as tr. iodine, croton oil, and vesicatories.

The treatment of diarrhœa is of great importance, because it may be but the beginning of choleraic diarrhœa. In these cases the danger is imminent. In these cases give a spoonful of coffee and Malaga wine, and coffee and brandy. If possible, a wine bath should be given; this stimulates the functions of the skin, and should only last five minutes.—*Jules Simon, in Journal de Therapeutique—Southern Med. Record.*

OBSTETRICS.

Note on Delivery of the Placenta.

Prof. CHAS. JEWETT, M. D. (Proceedings of Kings County Medical Society.)

The diversity of usage which still obtains in the management of the third stage of natural labor, prompts this brief note, in the hope of eliciting the views and practice of the Society.

The points to which I wish especially to invite attention are the method and the time of placental delivery. These comprise the larger part of the treatment of the placental stage, the management of which is, perhaps, the most important office of the obstetrician in the conduct of natural labor.

The preferred method of delivering the placenta is that of Crede, of Leipzig. In Germany this method is now

used to the exclusion of almost every other, and it would seem that so eminently judicious and rational a procedure could not fail of universal adoption. That such is not yet the case, is possibly due to the fact that in many of the standard works on obstetrics, the Credean method, if mentioned at all, is more or less imperfectly stated.

The essence of the German method is compression of the uterus during contraction, and with but slight downward pressure. It is practiced as follows: The obstetrician laying his hand flat upon the abdomen of the patient, stimulates the uterus to contract by moving the abdominal wall in a circular manner over it. The friction, gentle at first, is increased till a contraction occurs. At the height of the contraction the upper segment of the uterus is firmly grasped with the hand, the fingers over the posterior, and thumb over the anterior surface. The placenta is thus expressed, only enough downward pressure being used in the uterine axis to maintain a firm grasp. Failing in the first attempt, the compression may be repeated with each contraction till successful, friction being continued meantime to maintain the retraction thus far accomplished, and to provoke further uterine efforts.

It is the peculiar merit of this method that it, more closely than any other, imitates the natural process of placental expulsion. Moreover, it is designed to supplement the expulsive efforts of the uterus, not to replace them. It maintains firm retraction till the afterbirth is expelled, keeps the uterine vessels securely ligated, and prevents the formation of deep coagula in the uterine sinuses. It favors, more than any other plan, permanent retraction after the delivery of the placenta. Potent for good, it is incapable of harm.

Some practice is undoubtedly neces-

sary to the utmost facility in this procedure, but the knack once acquired, other measures will be very rarely called for.

With reference to the time of placental delivery, the prevailing practice, in the judgment of the writer, favors too long delay. Dr. Playfair, following the teachings of McClintock, says that no attempt should be made at delivery of the placenta till twenty minutes after the expulsion of the child. Certain other obstetric writers sanction even longer delay. The arguments of Dr. Playfair in support of his practice are that time is thus allowed for recovery from the shock or exhaustion of the second stage, for the separation of the placenta, and for the formation of coagula in the uterine sinuses. While these would be valid reasons for delay under the old practice of placental extraction, they do not forbid early resort to the Gredean method.

There is surely no exhaustion of the uterus when it can be provoked to contract by gentle friction. Again, the very agency by which separation of the placenta is accomplished is uterine contraction and retraction. Against the dangers of post-partum hemorrhage, the chief security lies in the ligation of the uterine vessels by retraction of the muscular structures. Coagula in the uterine sinuses are a feeble barrier against hemorrhage. Moreover, thrombi extending into the intermuscular portion of the uterine veins, are a positive source of danger, from their liability to infection. Promptness, again, facilitates delivery. By too long waiting the way may be narrowed by the contraction of Bandl's ring, and the difficulty of expulsion be thus increased. As a rule, then, the placenta should be expelled as soon as its function is ended; that is, as soon as the infantile circulation is established and the cord divided.

A word with reference to the use of ergot may not be out of place. Prof. Lusk disparages the exhibition of this drug before the afterbirth is delivered, owing to its tendency to induce so-called hour-glass contraction. In my practice a drachm of the fluid extract of ergot is given by the mouth in every case—or its equivalent hypodermically—as the head passes the vulva. Under the above management of the placenta, it is expelled before the effect of the drug is developed. I should be unwilling to sacrifice the advantage gained by the early use of ergot, through fear of a possible danger so seldom realized.

In conclusion, I submit the following summary:

Use constant friction or uterine massage after the delivery of the head, for the double purpose of maintaining retraction and provoking uterine effort.

Supplement the uterine efforts, if need be, by compression.

After the placental expulsion, continue friction till retraction is complete and permanent.

Use ergot on the birth of the head to promote the prompt and perfect completion of the third stage.

Aim to deliver the placenta, as a rule, directly after, not before, the ligation and division of the cord.

Post-Partum Hemorrhage.

Two cases of hemorrhage after delivery, cured by injection of the tincture of the chloride of iron (diluted, 1 to 4), are reported by Herbert Thompson in the *British Med. Journal*.

Hour-Glass Contraction Treated with Nitrite of Amyl.

Dr. FANCOURT BARNES reports a case to the *British Medical Journal*, and we abstract from report in the *American Practitioner*. The patient had been de-

livered by a midwife, Dr. Barnes being called to deliver the placenta. Ergot had been given previous to the arrival of Dr. Barnes to promote placental expulsion. The effect apparently was to excite spasm of the internal os; so much so that the doctor found it impossible to get his hand into the uterus. Bearing in mind the remarkable power which nitrite of amyl possesses in relaxing tension in the blood-vessels, he determined to test its action on the uterine spasm. Three drops of the nitrite of amyl were given on a handkerchief to inhale. "The ring of muscular fibres round the os internum, which had been so rigid as to be absolutely undilatable, steadily yielded until I could pass the whole hand into the uterus and detach the placenta." There was no hemorrhage. Referring to the work of Dr. Robert Barnes on Obstetric Operations, he quotes the following in regard to the antagonism between nitrite of amyl and ergot: "We possess in ergot a great, a dangerous power of augmenting the force of the uterus. We want an agent endowed with the opposite effect that will control and suppress uterine action. I consulted Dr. Richardson on this point. He tells me the desired power exists in the nitrite of amyl. Three minims of this added to one drachm of ether, taken by inhalation, is the form he recommended. It does not produce unconsciousness, but it is an anesthetic as well as a sedative of muscular action. It is the antidote or opposite force to ergot. In it we have the desired 'epechontotic agent.'"

Sinclair on Treatment of Subinvolution of the Uterus.

This writer (*Boston Med. Jour.*) gives the following as a plan which has given him much satisfaction in the treatment of these cases :

1. To rectify the displacement which, if it existed for some time, has given rise to endometritis and increased vascular engorgement.

2. To reduce vascular turgidity by local bleeding, repeated at intervals of from seven to ten days.

3. Memorrhagia usually dependent on an altered state of the endometrium, relieved by the use of the wire curette; so, also, the morbidly altered cervical glands.

4. To promote healthy and absorptive action of the endometrium and cervix, Churchill's tincture of iodine is applied by means of a probe covered with absorbent cotton, or injected into the uterus by aid of a double catheter. This may be used once a week.

5. Daily vaginal enemata of water at a temperature of 115° F.

6. If there be deep and gaping laceration of the cervix, repair by plastic operation as indicated; although what appears to be a pretty deep fissure on first examination becomes shallow and insignificant after a course of treatment.

7. General constitutional treatment. This must vary with the conditions present, but generally a mixture containing sulphate of iron, dilute sulphuric acid, and sulphate of magnesia with ergot, is given to strengthen the system and diminish local plethora.

8. Suitable diet and clothing.

9. I have not ordered rest in the treatment of these cases, provided patients could take exercise, for I have found less chronic invalidism accompany uterine disease generally where the subjects of them were advised to go into the open air as much as possible, and to avoid passing their days on the bed or sofa.

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Exfoliative Metritis.

Dr. H. J. GARRIGUES (*Med. Rec.*) presented a specimen before the New York Pathological Faculty illustrating the above.

The patient had diphtheritic ulcers of the vagina and of the uterus, which were treated by cauterization with chloride of zinc. For the ulcers in the vagina he used equal parts of chloride of zinc and distilled water; for the uterus an eight per cent. solution was injected, after first washing it out carefully with carbolic water. It was also washed out a second time after the injection of the chloride of zinc solution. She also had an offensive diarrhoea, from which she recovered under treatment. The vaginal ulcers healed almost completely, the offensive discharge from the womb ceased, but the organ remained very greatly enlarged, extending almost up to the umbilicus. From time to time the temperature would again run up, and on one of these occasions the uterus was again washed out with the carbolic solution, as had been done so often before with great benefit; but on this occasion she went into collapse and died in a few moments. At the autopsy the uterus was found ruptured in two places, anteriorly and posteriorly, the first rupture being three inches in length, the second less. At these points the walls had become as thin as a piece of paper, but the ulcers had healed perfectly. To the walls of the uterus were found adherent coils of the small intestine, and at two places there were fine canals leading into

the intestine. More interesting still was a body, lying perfectly loose in the interior of the uterus, four inches long, two inches wide and one inch thick. Microscopical examination showed that it was a part of the wall of the uterus which had been sloughed off by an ulcerative process which had burrowed beneath it. Muscular tissue of the womb could be distinctly seen, interspersed everywhere with inflammatory material. The condition should not be confounded with gangrene of the womb, an entirely different affection. As rare things tend to repeat themselves, so recently Dr. G— had a similar case, the exfoliated part being a larger and longer piece of muscle. Evidently this body had acted as a valve, preventing the exit of the fluid during the injection, and had caused the rupture of the very thin uterine walls. This was a patient at Maternity Hospital. He had found the record of but two similar cases in the medical literature.

[This rare case adds one more to the list of conditions in which it is dangerous to inject the uterus.]—A. J. C. S.

Abortion.

A case of this kind, involving some curious medico-legal points, was recently tried in Chicago. A girl died recently from metroperitonitis. A midwife was tried of causing her death by attempt to produce abortion. The autopsy showed that there had been apparently an attempt to produce abortion, but that the girl had never been pregnant.—*Chic. Med. Review.*—*Med. Gazette.*

Is Conception Possible after Double Ovariectomy?

Dr. BOISLINIERE (*St. Louis Courier of Medicine*) says that he knew of three cases where conception and safe delivery had occurred after double ovariectomy. The Fallopian tubes, or one of them, may remain after the operation, and may be connected with a portion of the ovarian stroma also remaining, so that ovulation and menstruation may continue. It is said that each ovary contains 350,000 Graafian vesicles capable of becoming impregnated when they come to maturity, so that a woman with both ovaries contains enough possibilities to populate a city larger than this. It is not only the stroma that contains ova, but the ovigenic layer surrounding the stroma, and a part of this layer might be left after the operation of double ovariectomy, and the Graafian vesicles find their way thence into the Fallopian tube. Dr. Maughs had stated that he did not believe that he had removed all the ovarian tissue in his cases, and it was quite possible that Dr. Englemann had not removed all the tissue, as he scooped it out with his hand. Then there was always the possibility of the presence of supernumerary ovaries. Of course, if the Fallopian tubes were all removed entire, there would be no opportunity for the ova to enter the uterus, and conception would be impossible, unless the spermatozooids had reached the ovary through the duct of Gartner—this duct is always found in the sow, and occasionally in the human female.—*American Medical Weekly*.

When to Ovariectomize?

WALTER F. ATLEE, of Philadelphia (*Maryland Med. Jour.*):

So long as an ovarian tumor does not interfere with the appearance, prospects

or comforts of the patient; so long as no injurious pressure is exercised by it on the organs of the pelvis, abdomen and chest; so long as heart and lungs, digestive organs, kidneys, bladder and rectum perform their functions without much disturbance; so long as there is no great emaciation, no very wearying pain, no distressing difficulty in locomotion, or so long as any injurious influence can be counteracted by ordinary medical care, the patient should be left to *this care*, undisturbed by any surgical treatment.

Treatment of Membranous Dysmenorrhœa.

Dr. ORSBY (*New York Medical Record*) gives five cases of painful menstruation, accompanied by the shedding of flakes of membrane, successfully treated with calomel in combination with opium. His formula is as follows: \mathcal{R} . Ext. opii, six grains; hydrarg. chlo. mit., twelve grains. Divide in twelve pills, one to be given every four hours till the gums are affected. He regards the known efficacy of mercury in all forms of hyperplasia, acute and chronic, as justifying a priori its exhibition in a complaint in which the hyperlastic element is recognized by pathologists, and his practice has completely confirmed this view. Calomel has been the only salt of mercury tried, as it produces its effect rapidly and with little irritation.—*Chic. Med. Review*.

[In the treatment of this affection we have frequently used bichloride of mercury, in medium doses, with apparently good effects.]

A. J. C. S.

Membranous Dysmenorrhœa.

Dr. LUTAND (*Ann. de Gynecol.*) concludes from a study of this subject: 1st. That membranous dysmenorrhœa consists of an exfoliation of the hypertrophied uterine mucous membrane. 2d. The expulsion of the mucous membrane does

not take place each month; several months may elapse between each expulsion. 3d. This affection is quite common in virgins, and can, therefore, not be regarded as the result of conception. 4th. It nearly always causes sterility.

For Uterine Granulations.

R. Adipis, $\frac{3}{4}$ ss.; hydrarg. oxidi rubri, gr. xv.—M.

A tampon smeared over with this ointment should be placed in contact with the cervix (through the speculum). The application should be removed every day after the use of an astringent or detergent wash. (Infusion quercus, for instance.)—*Mich. Med. News.*

[There is danger of salivation from this treatment.] A. J. C. S.

Chlorosis.

In reply to a question in the *Med. Brief* for the treatment of this disease, Dr. J. ASHWORTH, replies as follows:

I would advise the following as being excellent:

R. Hydrastin, 30 grains; quiniæ sulph., 30 grains; ferrum by hydrogen, 30 grains; ext. nucis vom., 10 grains.—M. Div. chart. 20. Sig.—One thrice daily, for one week.

Followed up by the following:

R. Com. tinct. cinchon., 4 ounces; ext. gentian fl., 1 ounce; fluid hydrastis, 1 ounce; pepsin, $\frac{1}{2}$ ounce; nitro-muriatic acid, $1\frac{1}{4}$ drachms; tinc. nucis vom., $2\frac{1}{2}$ drachms. M.—Sig. One teaspoonful, three times daily, in water.

Give the above two remedies on alternate weeks till nearly cured, when you will complete the cure with the following:

R. Pure glycerine, $\frac{1}{2}$ pint; acid phosphor., 4 ounces; tinc. iodinii, 1 drachm. M.—Sig. Tablespoonful twice daily,

with four to six grains of fresh ox-gall at bedtime.

Have your patient take a daily bath of water, slightly acidulated with hydrochloric acid. Eat nothing but very nourishing food, such as fresh beef, eggs, milk, oysters, etc. Abundance of fresh air, moderate exercise, warm clothing, thorough hygiene. She may take the last remedy in good Burgundy port wine.

[This treatment may be efficient in relieving some of the conditions present in chlorosis, such as anæmia, but it is doubtful if the peculiarities of organization present in chlorotic women is ever "cured."] A. J. C. S.

Treatment of Malignant Growths of the Mammæ.

Electricity and iodide of potassium are claimed by Professor MARIANO SEMMOLO as effective means of curing malignant growths of the mammæ. A galvanic needle is introduced into the growth and a weak current of electricity allowed to pass through it for some time. The séances should not exceed three per week. Large doses of iodide must be given meanwhile to modify nutrition. Cure is obtained by cicatricial tissue, by colloid or fatty degeneration, by sloughing.—*Chic. Med. Review.*

An Alleged Improvement in Emmet's Operation.

In the *American Journal of Obstetrics* for July, Prof. CARL SCHROEDER, of the University of Berlin, discusses "the relation of cervical lacerations to catarrh of the cervix uteri and the necessity for Emmet's operation." The author thinks that cervical laceration uncomplicated with catarrh of the cervix is of rare occurrence, especially if the laceration be a deep one. In such rare uncompli-

cated cases where the ordinary symptoms of pelvic pains, dragging, tenderness to the touch, etc., are referable to the laceration, he thinks Emmet's operation is proper; but in all cases of laceration complicated with a catarrhal condition of the cervix, he is of the opinion that said operation is not only unnecessary but improper. Cervical erosions, where the one layer of normal cylindrical epithelium is replaced by several layers of the pavement variety, are considered as rather the cause than effect of lacerations; and to remove the latter would be to embarrass the treatment of, instead of to cure, the former.

The author proposes an improvement, or, more properly speaking, a substitute for Emmet's operation, proper in a great majority of the conditions for which the latter has been proposed. It consists in removing the everted and thickened mucosa of the cervical canal along with the surface of the laceration. When these parts are removed the anterior and posterior lips of the uterus present two rectangular flaps, with the apex of the V-shaped space which is left on a level with the vaginal insertion. In closing, these flaps are doubled upon themselves and stitched in such a way that the mucous membrane formerly covering the intra-vaginal portion of the lips and vaginal vault, is drawn upwards so as to replace the diseased structures removed by the operation.

The operation is simple, attended with very little bleeding, and is said to cure both cervical laceration and catarrh.—*Ibid.*

Herpes Niger of the Labia Majora.

The woman, twenty-one years of age, was at the end of her gestation. There was a gangrenous patch on the lower part of the abdomen, eight cm. long and

six cm. broad, near the pubis. After parturition a high fever set in, the lochia being normal; pulse, 140; no vomiting. On the right labium there appeared some spots of herpes, which extended all over the pubes in the next three days, the fever increasing at the same time. The vesicles contained a dark-colored fluid, and they were isolated. The gangrenous patch began to heal, but the herpes spread to the perineum. The patient died after six days.—*L'Union Médicale.—Med. Jour. and Examiner.*

Vaginal Hemorrhage in a New-born Child.

Dr. JOSEF POLLAK, in Devecser, reports the following case in the *Wien. Med. Presse*. He observed in a female infant, four days old, a not inconsiderable hemorrhage from the vagina. The bleeding reappeared several times daily; after the third day the discharge assumed a reddish-brown, and later a chocolate color, and ceased totally when the infant was nine days old. At the same time there was noticed a swelling of the mammae, and on pressure a milk-like fluid oozed from them, drop by drop. The general health of the case just reported did not apparently suffer at all in consequence of the bleeding.—*Med. Record.*

Hæmatocoele Retro-uterine.

(Prof. BRAUN'S *Clinic*. Vienna.)—Defined to be, since Nélaton, a collection of blood in Douglas' space, the menstrual fluid being poured into the peritoneal cavity instead of the uterus.

The ancients recognized it as "suppressio mensium." "Parametran exudate," and blood extravasation in the peritoneal sac is met with monthly in sterile women, or those who have not borne in a long time. Extra and intra-

peritoneal hematocele are the varieties, the latter being the most frequent. Contrary to French views, it is not always found in connection with extra-uterine pregnancy, but they always co-exist, and therefore milk should be sought for in the breasts, and the genitalia should be examined for the bluish color of pregnancy. It is much easier to determine that it is the result of pregnancy than it is not. Prof. B. related a case in point, in which he was called in consultation by a homœopath. The patient had a large elastic growth in the pelvis, and suffered from violent abdominal pains. Prof. B. said if its size remained stationary or diminished, it was a blood extravasation; if it increased it was an extra uterine pregnancy. The attending physician ignored the latter possibility, as the husband had been impotent ten years, and the wife came from a distinguished family. The growth grew, milk was secreted, the patient became worse; he was called again, but arrived just after her death, which was the result of a vessel bursting, its contents entering the peritoneal cavity. The autopsy showed an extra-uterine twin pregnancy. Hematocele is characterized by the following symptoms: Painful menstruation, often accompanied by prostration and chills, often sudden stoppage of the menses, pallor of the skin and mucous membrane, as the result of internal hemorrhage. In fatal cases the patient collapses, the bladder is compressed, ureters bent, the pulse is irregular, and death ensues. In favorable cases the tumor becomes encapsuled, and can be felt through rectum and vagina. In no other condition is Douglas' fold pressed down so deeply as in this and extra-uterine pregnancy; and during the first three months, diagnosis between the two is nearly impossible. It is distinguished from ovarian cyst by not being so

sharply bounded, and giving a tympanitic note on the percussion, coming from the folds of intestines, generally adhering to it as the result of inflammation, and there is no fever with the cyst.

The treatment consists in absolute rest in bed, abstinence from sexual intercourse, applications of ice to the abdomen, cold water injections, regularity of bladder and bowels, removing all complication. Nélaton advises puncture through the vagina in cases accompanied by continuous fever and pain, but this is not advisable if the least suspicion of pregnancy exists.—*Obstet. Gazette.*

Gangrene of the Bladder from Retroversion of the Gravid Uterus.

The last number of the *Archiv für Gynäkologie* contains an interesting article on the above subject by Dr. G. Krukenberg, of Bonn. He points out that cases of rupture of the bladder and of gangrene of the bladder, from retroversion of the gravid uterus, are identical in their pathology. When gangrene of a portion of the vesical wall takes place, its peritoneal surface may be or may become adherent to neighboring parts, and in that case the gangrenous bit (or layer) may be cast off entire or broken up. If no adhesion be present, and the bladder be subject to distension, its wall will give way at the weakened spot, or the separation of the slough may lead to perforation, even without over-filling of the bladder. Dr. Krukenberg has only been able to collect ten of these rare cases, and to these he has added one observed by himself. The practical conclusions which he draws from them are these: When the catheter has been employed and the uterus replaced before the sixth day, exfoliation of a portion of the vesical wall has never been observed.

If regular catheterization is begun before the tenth day, rupture of the bladder need not be feared. When retention of urine persists longer than this, either gangrene or rupture of the bladder may supervene, rupture being the more frequent. Rupture of the bladder may also take place suddenly from great distension of the bladder or from efforts even most carefully made to replace the uterus. If gangrenous portions of the vesical wall are cast off, it should be an indication to abstain from attempts to replace the uterus (lest rupture of the bladder should take place), and to treat the case by the induction of abortion.—*Med. Times and Gazette.*

Uterine Hemostatics.

By J. BRAXTON HICKS, M. D., F.R.S., etc., Obstetric Physician at Guy's Hospital, and Lecturer on Obstetrics, etc.:

As a small contribution to the practical portion of the subject of uterine hemostatics, I venture to make a few remarks on the mechanical kinds, which we know by the name of plugs or tents. In doing so I must be understood to refer only to those cases where the cavity of the uterus is not sufficiently large to contain blood in quantity, the loss of which from the circulation is likely to produce any thing of serious detriment.

If we go back to former practice and to text-books we find it recommended that in case of threatened abortion with much hemorrhage, a vaginal plug should be used. The vaginal plugs recommended are the tampon, cotton or wool, silk or cambric handkerchief, rags, or sponges passed in till the vagina is filled up. An India-rubber ball also has been suggested, covered with felt or such like material. Now, even with the best management there is much of distress to the

patient in the use of the vaginal plug; and with regard to its hemostatic effect very much of uncertainty, and generally partial failure; and in the hands of the unskillful and careless there is positively no restraint of bleeding worth the mention. If at any time any good results be produced, it is rather by the reflex irritation that it causes, whereby the uterus expels its contents. It is not so very rare an occurrence that one finds, on removal of the plug, the ovum on the uppermost part of it. But besides its palpable inefficiency, a vaginal plug, being of a porous texture, absorbs a large quantity of blood and thus conceals it from our sight; it also favors decomposition, and this, as is well known, occurs within a few hours; and thus we have a new element of danger.

Again, in many cases, when called to such a case, we have no speculum at hand; and although we may extemporize one out of card-board, book-covers, or such like material, yet, before we have thoroughly and firmly filled the vagina we must have given the patient considerable pain and distress, besides having occasion to put such pressure on the urethra as may necessitate subsequent catheterism. For these reasons, namely, the imperfection of action, pain in introduction, and danger if left in long—in other words, its general crudity, it seems to me that as a general rule the vaginal plug should, in the cases I have supposed, be discarded. And as a substitute I would urge the employment of the cervical plug as being more precise in action, as well as being capable, if we use a dilating kind, of expanding the canal for the purpose of exploration, or for the expulsion or removal of its contents.

If, then, in any case of uterine hemorrhage where we have the conditions above alluded to, we desire, besides im-

mediately checking the bleeding, to dilate, we can use the compressed sponge-tent; the best form of which I have found to be those made after Sir James Simpson's plan, by Duncan, Flockhart & Co., of Edinburgh. These can be introduced by a long pair of forceps, and retained *in situ* by placing a piece of sponge, with tape attached, in the upper vagina. Of course, even these materials retain some secretions, etc., and tend to facilitate decomposition; but their removal and cleansing can be effected much more readily than the vaginal plug, because it requires but a small portion. The sea-tangle tent, by reason of its slipperiness, is unreliable as a plug in hemorrhage. If we desire, however, only to plug the cervix, we can very easily extemporize a plug from materials to be found in every house. For instance, take a stick (say a flower stick) about a foot long, and taper it at one end to about the size of an uterine sound, or rather larger; wind round this end, for about three inches down, strips of cambric rag, lint, or sponge to the required thickness, judging from the size of the os. Strips of sponge can be readily obtained from cup-shaped sponges of compact texture, and they can be tied on by thread, layer after layer, till the requisite conical form is obtained. The strips of the other material can be laid on similarly. After the covered end has been well greased it is passed into the canal and the stick retained *in situ*, after the manner in which we tie in a catheter; an elastic tape, if obtainable, is to be preferred.

A catheter or bougi, or the end of the long injection-tube, can be treated in the same way. If we require great precision of application, then it is best that the hand should hold the external end till the hemorrhage has ceased. If the catheter and stilet be used, then I have

found it convenient to bend the external portion backward, between the buttocks, tying the tape round the ring of the stilet—the ends of the tape being carried, as usual, to back and front of the waist-band.

These more homely adaptations I have recommended, rather than the especially made kinds, because they are often wanted at times when we cannot send home for a more showy sort. In any case, a cervical plug, expanding or not, is more precise, less crude and painful in application, than the vaginal, and, in my experience, nearly always successful. In all cases of abortion, where a plug is necessary, I would lay it down as a rule that the expanding tent should be employed. In cases of flexion with abortion (and it is this complication which so frequently increases the hemorrhage) it will be found that the covered stick or stemmed plug above described is very useful; for, if the fundus be elevated during its introduction, the uterine cavity is straightened and evacuation of the contents thereby facilitated.—*Brit. Med. Journal.*

DISEASES OF CHILDREN.

Preventing Bowel Diseases in Infants.

Dr. N. S. DAVIS, in a paper read before the American Medical Association, states that our efforts to lessen infant mortality from these diseases must embrace such measures as will secure for young children a better supply of fresh, pure air, for increasing the oxygenation and decarbonization of the blood and maintaining the activity of the vaso-motor nervous system, and as well counteracting the effects of high temperature by increasing the general tonicities and lessening the excitability of the tissues generally. Measures for the first object

must consist in securing better ventilation of dwellings, and especially nurseries and sleeping rooms, during the warmest part of the summer, the sending of young children with their mothers and nurses from densely populated districts to moderately elevated, healthy locations, or to floating hospitals, receiving ships, or large bodies of water, during the special period of high heat. For accomplishing the second purpose, he knew of no measure so efficient and at the same time within the reach of the poorest part of the population, as the judicious use of the *sponge bath*. Whenever the human system is relaxed and rendered morbidly sensitive by continuous high heat, causing the infant to be languid, restless, and sometimes pale, a free bathing or sponging of the whole surface with water simply as cool as it is comfortable always produces a refreshing and invigorating influence, which continues from six to twelve hours. Consequently, if mothers and nurses could be so instructed by their family physician that, during every wave or period of high atmospheric temperature in which the mercury did not fall below 70° F. during the night, each child under two years of age should be regularly given a bath in the evening as well as in the morning, and their sleeping rooms should be as well ventilated as possible, such a course would diminish the attacks of serous diarrhœa and cholera infantum one-half, and consequently very greatly lessen the infant mortality from these affections.

It is well known to every careful observer that a large majority of all the attacks of this form of disease show their first beginning during the last half of the night or early in the morning, owing to the long continuance of the high temperature, coupled with the more still and confined air of the night. The

increased tone of the whole vascular system produced by the stimulant and tonic effect of a comfortably cool sponge-bath on the function of the vaso-motor nerves, applied in the evening, would enable thousands of these little restless sufferers to pass the whole night unharmed, when without it the dread weakness would begin.—*Sanit. Engineer.*

Quinine in Cholera Infantum.

Dr. OTIS F. MANSON (*Trans. Virginia Med. Society*). When called to see a patient *at night*, along with the means already advised, you will now make an important addition to your treatment. We usually, unless the case is very urgent, postpone the administration of the grand remedy, quinine, until the late hours of night. Then the violent excitement and commotion of the exacerbations have passed. The stomach is then not so irritable. Quinine, a *sedative and narcotic*, is assisted in its action by the *physiological tendency of the nervous system to repose in the night season*, and you have ample time to exhibit enough of it in order to prevent the threatened exacerbations of the next day. I am sure that the remedy is better borne, and produces its salutary effects in the most perfect manner, when exhibited in the late hours of night. At midnight, then, we can commence its use. To an infant of six months of age and under, we give a grain of sulphate of quinine with a few grains of white sugar, diffused in a teaspoonful of cold water. To a child of twelve months, we give two grains of quinine, and to one of eighteen months, three grains. If the dose is immediately *rejected*, we repeat it over and over again every half hour. After a few repetitions enough will be absorbed by the mucous membrane of the mouth and stomach, or by the former

alone, if it is not even swallowed, to bring the little patient fully under its influence. If the first dose is, however, entirely *retained*, we allow the patient to rest for three or four hours. We then repeat the dose, and continue to repeat it until the thermometer in the axilla and the finger on the pulse indicate that rapid sedation is ensuing. In the large majority of cases, these effects will follow from the administration of the sulphate. The pulse will become slower and less active and bounding; the head will become cooler; and the extremities, if previously below the normal temperature, will become warmer. Not only this but the vomiting will become less frequent, or will often *entirely cease*. *After the first dose of quinine has been absorbed*, the bowels will become more quiet, and the renal secretion more copious. The little sufferer will become tranquil, and fall asleep, sometimes for hours without awaking; but it can be easily aroused, if necessary. The *narcotism* produced by quinine, in this respect is *unlike* the stupor produced by *opium*; and besides this, instead of having a tendency to produce congestion of the brain like opium, it has, *beyond all other remedies*, the power of *removing an excess* of blood from the cerebral vessels. In five or six hours after the administration of quinine has been begun, in the large proportion of cases, seen early in their course, the fever will have *disappeared*. When this occurs, cease medication for the day. On the next afternoon or night, a slighter exacerbation will often make its appearance, and this may recur for two or three nights thereafter. In this same case, repeat the quinine in similar or diminished doses, *giving it more freely in direct proportion to the violence of the fever*.

At the same time, we continue the calomel, or employ blue mass, until the

presence of pure, healthy bile in the dejections is perfectly evident. Now that the fever has vanished, you may associate opium in minute doses with the mercurials. If blue mass is given, have it triturated in a teaspoonful of simple syrup, and add the laudanum to it.

Viability of Premature Children.

Prof. SPATH recently expressed himself as a believer in the very early viability of premature children (*Wein. Med. Zeitung*, May 20, 1882.) After speaking of the generally accepted opinion that children were not to be considered viable until after the completion of seven lunar months' gestation—twenty-eight weeks (the Prussian law pronounces a fetus viable that has been carried thirty weeks)—he went on to say that his own observations warranted him in making the statement that a fetus could be kept alive out of the sixth month even. Of course, the sixth lunar month is from the end of the twentieth to the end of the twenty-fourth week of utero-gestation. Particular care would naturally be demanded in bringing up such youngsters. Enveloping the child in cotton wadding was an admirable method of preventing loss of the low degree of body-heat such children possessed. The weakness of the digestive powers should be met by giving such milk as contains but a small amount of casein. As observation shows that the milk of women becomes richer in casein the longer they suckle, only young girls should be made choice of as wet-nurses who have been recently confined. It was also necessary that the young person chosen should have long nipples; for as the infant itself would be too weak to suck and swallow, the nipples ought to project deeply into the mouth, so that the milk might in a manner run of itself into the

stomach. Professor Spath himself had a case under observation in which a child born *in* the sixth lunar month was successfully brought up in the manner above stated, the child being at the present time six years old, and quite as well grown and strong as its brothers and sisters born at full term. He remarked, in conclusion, that the great mortality of premature children was easily comprehended when one bore in mind the ordinary high death-rate during the first year of infant life.—*Med. Press and Circular*.

An Undescribed Disease of the Newly Born.

From the most prominent symptoms the author has described this disease under the name of "Cyanosis febrilis enteritica perniciosa cum hemoglobinuria."

He observed the disease in its endemic form, and gives the results of his investigations as follows:

Death took place in eighty-two per cent. of the twenty-three attacked. The disease makes its appearance on the first, second, or sometimes as late as the fourth day after birth.

Symptoms.—Cyanosis, icterus; urine of a light color or more or less of a dark-brown, which may contain hemoglobine, normal bladder epithelium, large quantity of "granular casts," red blood corpuscles, micrococci, detritus, urate of ammonia, and a small quantity of albumen; subnormal temperature; frequent dark, yellow, alvine discharges; increase of the white blood corpuscles, and the blood contains the remains of the broken down red corpuscles and movable bodies. No increase or hardening of the connective tissue; liver a little enlarged, almost entire absence of "chest symptoms," convulsions, subsultus, nystagmus, convergent strabismus.

Post-mortem examination revealed

the following changes: Infarction of the papillæ of the kidney, dilatation of the stomach, ecchymoses in the intestines; enlargement of Peyer's and the mesenteric glands, hyperemia and congestion of the mucous membrane of the larynx and bronchi; edema of the brain, dilatation of the ventricles, congestion, with here and there effusion of blood. Of the etiology nothing is known.—*Praktizirende Genesheer.—Obstet. Gazette*.

Cough of Infantile Pneumonia.

In the transaction of the Medical Society of Virginia, Dr. BEDFORD BROWN read a paper on the pathology and treatment of infantile pneumonia, reported in the *Medical News*. We abstract the following: In proportion to the extent and gravity of the lung disease the cough diminishes in frequency and force, and thus declines to aid expectoration. Such a condition needs artificial stimulation of the function of coughing. The agents used are antiseptic, they disinfect the accumulated matter in the bronchial tubes, and excite these tubes to action, and hence the expulsion of the offending cause. Dr. Brown uses, by spray apparatus, three or more times a day, this solution: Alcohol, one ounce; water, two ounces; carbolic acid, half a drachm; salicylic acid, one drachm; chloral hydrate, half a scruple. The atmosphere surrounding the head and chest as well should be charged with the spray, whenever necessary, to excite cough and expectoration. This has always, in his experience, been efficient, with improvement in the breathing and complexion—at least for the time being—and in some cases he has thereby saved life.—*Chic. Med. Review*.

Rectal Polypi in Children.

Prof. N. J. BYSTROFF bases the following conclusions upon the notes of thirty-one cases of polypus of the rectum in children, observed by him in the last seven years: The chief symptoms of this condition, in some cases the only one, is the presence of blood in the stools, in quantity varying from a few drops to an ounce. The bowels may be regular, or there may be either constipation or diarrhœa. Pain is seldom complained of, but there is nearly always tenesmus. The pathognomonic sign is the protrusion of the tumor, though sometimes, from its situation high up in the rectum, this does not occur. The color of these tumors is darker than that of the rectal mucous membrane. The size varies from that of a pea to a plum, or even larger. The shape is rounded or egg-shaped, seldom pyriform. In consistence the tumors are soft; the surface is usually smooth, though sometimes rough and uneven. The polypi were located in two-thirds of Bystroff's cases on the anterior wall of the rectum, in one-third on the posterior, and for the most part between the internal and external sphincters. Multiple polypi were not observed. The general health was somewhat impaired through the repeated losses of blood. The youngest of his patients was two years and eight months old, the oldest 13 years, the average age being, in boys, 6.8 years; in girls, 7.4 years. The sex seemed to have no influence. A polypus is often mistaken for prolapse of the rectum, but the absence of a round opening in the centre of the tumor and of increase in size when straining will serve to exclude the latter. Polypi are more rare than prolapsus; the latter occurs in young children, the former is seldom observed in children under three years of age. In

two cases a diagnosis of hemorrhoids had been made—a very rare disease in young children. A change of size, under varying conditions, the presence of other varicosities, and the absence of pedicle will suffice to distinguish piles. From dysentery, polypus is to be differentiated by the absence of fever, presence of tumor, passages which are streaked, not mixed, with blood. An irritating enema suffices usually to bring the polypi to view, or they may be detected by digital examination, or through a fenestrated speculum. Spontaneous separation of the polypus can occur. Its surgical removal is accomplished often previous to ligation of the pedicle by the knife or scissors. Bystroff does not favor the use of the cautery in these cases.—*Deutsche Medicinal Zeitung.—Medical Record.*

OBSTETRICS.

Etiology of Puerperal Eclampsia.

Dr. T. HALBERTSMA, "On the Etiology of Puerperal Eclampsia," in *Wien. Med. Woch.*, says that all previous observations on the cause of eclampsia are giving way, and seeks for a new clear foundation. He has now for an entire year declared that puerperal eclampsia might be caused by the pressure which the ureters receive from the side of the extending uterus. This hypothesis then met with contradiction; this could not be the exciting cause, as we do not meet with eclampsia in ovarian tumors. Whereupon he attempts to establish afresh his hypothesis. 1. The ureters pass around the uterus from above and behind, to before and below, and can very easily be compressed. This relation does not exist in the case of the ovaries. 2. By experiment it is clear

that the secretion pressure in the kidneys is always very slight; therefore, if both ureters are compressed, the flow of urine can easily be stopped. 3. Clinical observation teaches that a small evacuation of urine is one of the strongest fore-running symptoms of eclampsia, and that this retention can almost invariably be traced to the compression of the ureters.

[That the ureters are thus subject to compression by the gravid uterus is, from an anatomical standpoint, extremely doubtful.

This theory is certainly inconsistent with the occurrence of albuminuria in the early months of pregnancy, and with the fact that the majority of cases wholly escape renal disorder.]—J.

Puerperal Convulsions Treated with Veratrum Viride.

Dr. JOHN BROWN, Williamsburg, Ohio, (*Obstet. Gazette*), reports the following:

Mrs. B., aged 20 years; primipara; patient of Dr. LANCASTER, of Mt. Oreb; taken in labor on the morning of the 17th of April; after a moderately easy labor, was delivered of a healthy child at one o'clock on the afternoon of the same day. About an hour after delivery she complained of severe pain in the head, whereupon the Doctor prescribed thirty drops of bromide of potassium, which was given; soon after she was seized with a convulsion. Convulsions recurred at intervals of 30 to 40 minutes, in spite of large doses of bromide of potassium and chloroform inhalations, until 7 P.M. Pulse then 130°, temp. 101°F.; Norwood's tinc. veratrum viride, ℥xl.; given per os. In 45 minutes, pulse 110; gave second dose of veratrum, ℥l. About one hour later, pulse 105; third dose of veratrum, ℥l. Pulse subsequently fell to 72. Four

and a half hours later, gave veratrum, ℥xx., with morph. sulph. (gr. $\frac{1}{2}$), hypodermically. Pulse now 74, temp. 98°. Recovery uninterrupted.

Puerperal Convulsions.

At a recent meeting of the Dublin Obstetrical Society (*Dublin Journal Medical Science*) Dr. RICHARD HENRY presented four cases of labor complicated by convulsions. After reading histories of the cases, he said: "In these four cases the distinction between true epilepsy and epileptiform convulsions is well marked, the fit in the former not returning except at the distant intervals the patient is accustomed to, and being no hindrance to recovery. In fact, no particular importance was attached to the fits in the first and fourth cases, once their true nature was apparent. Again, in the second and third cases there is marked distinction. In the second, the anasarca was general, invading the face, arms and legs, while in the third case it was confined to the ankles. In the second case the fits commenced before labor was concluded, and in the third when it was practically at an end. The second was infinitely more serious, and the question suggests itself whether the greater amount of uræmia not only brought on the fits before labor ended, but also increased their number and severity after it was concluded. The number of the fits (seventeen), the profound unconsciousness, the obstinacy of the bowels, and the good results following the old-fashioned practice of bleeding, and, above all, the complete recovery of the patient, are features worthy of note. Again, the question arises, does the bleeding, by speedily lessening the amount of uræmia, and by emptying the blood vessels rapidly, permit the resumption of nervous energy or tone of both

cerebral and sympathetic nerves, as shown by quickly returning consciousness on the one hand, and on the other, by the satisfactory motions from the bowels, as both systems seemed profoundly paralyzed by the poison? Also, are there not plethoric cases in whom convulsions might be more speedily cut short, and more safely also, by *bleeding*, than by any newer method? I remember a case some years ago, where the patient was bled to forty ounces before the fits ceased; no chloroform was used and she made a good recovery. Dr. Kidd, in discussion said: The fourth case is interesting, as showing that epilepsy occurring during labor is not such a very serious affection as uræmic convulsions. That point is very conclusively established by the paper. I have myself resorted to bleeding, but not with the good results recorded by Dr. Henry. Purging is the remedy on which I chiefly rely. It is often very difficult to get the bowels to act, and in several cases in the Coombe Hospital we have not hesitated to give 20 grains of calomel, and even to add to it some croton oil. The best of our recent observers have noted the good effects of large doses of calomel in cases of uræmia from kidney disease.—*Med. and Surg. Reporter.*

A Difficult Obstetric Case.

Read before the Grant County, Indiana, Medical Society, by S. C. WEDDINGTON, M. D.

On the night of January 1st, 1882, I was called to the assistance of Dr. H. D. Reasmer, of New Cumberland, Ind., in a difficult obstetric case, arriving a little after midnight. The lady, Mrs. R., is a middle-aged multipara—has some five or six children. She is rather large, well-formed, healthy, and has heretofore had easy labors. I was informed by

Dr. Reasmer that he had come to the case about eleven o'clock, A. M., on that day, and that on his arrival he found a face, or rather a brow, presentation; the forehead towards the right acetabulum; the chin towards the left sacro-iliac symphysis, and entirely above the superior strait. Also there was prolapsus of the cord which was pulsating very feebly and soon ceased; also one hand was beside, or in advance of, the face; the os uteri was dilated; the liquor amnii had escaped some time before his arrival; and the uterus had contracted firmly around the body of the child, the contractions being then strong.

The doctor made an effort to rectify the position of the head, but the contractions were so strong he could not. He then introduced his hand to effect podalic version, but the contractions cramped his hand. He succeeded in bringing down one foot, but could not reach the other; and the child was clasped so strongly by the uterus that he could not succeed in turning it. He then introduced the forceps, but could not get them to hold firmly enough to deliver; they would slip off.

He then asked for assistance. On examination I found the situation and conditions just as described by Dr. R., except that the child had then been dead several hours, and the uterus was probably more firmly contracted. I first made an effort to turn, but the uterus was so firmly contracted around the body of the child that I could not possibly reach the lower extremities (what some have called hour-glass contraction).

There was much anterior obliquity of the uterus, and the forehead of the child seemed to rest on the pubic bone. I introduced one blade of the forceps and tried to press it off, but I could not perceive that it moved. I then introduced

the other blade and made traction in the direction of the axis of the superior strait, making strong compression, as the child could not then be injured, and I soon found that the head was moving slowly. As soon as it began to move, the pains which had been frequent, sharp, cutting, but not effective, became strongly expulsive. We handled the forceps by turns, changing frequently; and by using all the force we could apply to the forceps, only while the contractions were strong, and using pressure above the pubes and over the fundus of the uterus a part of the time, we made slow but steady progress, completing the delivery at three o'clock A. M. After the face had reached the perineum the forceps slipped off once. The head receded a little and did not advance at all until they were again applied. I think there was no time, during the progress of the case, before the head had passed the inferior strait, when the unaided powers of nature could have completed the labor. Without aid the patient must have perished; and I think it was certainly good policy to give aid before her strength was exhausted.

Dr. Reasmer's forceps and mine are both of the same pattern, being what are called Brickell's, a modification of Hodge's forceps. We found, on comparing them, a little difference in the points of the blades, mine being more curved inwardly at the points than his, rendering his, perhaps, a little more easily introduced and a little less liable to hurt the child than mine, but not so well calculated to hold in a case requiring much force in traction. Applying the forceps so high made it necessary to make traction backwards and downwards, which he did, by using both leverage and traction, with one hand at the extremities of the handles and the other at the pivot. I thought of Tarnier's

forceps, but could not see how they could have been better than those we had, unless the traction rods could have passed through the sacrum. Short forceps, or very slender ones, of course, would have been of no use in the case. The question of craniotomy was raised, but from the height and position of the head and the difficulty of reaching a suture or of penetrating the os frontis, we thought it best to rely on the forceps.

The child was large, well developed, and seemed to have been healthy until the occurrence of labor. We remained some four or five hours after delivery. There was no untoward symptom. The lady seemed to be doing well, and said she felt nearly as well as after an ordinary labor. She made a good recovery.

[Several criticisms upon the management of this case suggest themselves.

A brow and hand presentation, unarrested, is not a case for forceps.

The use of the forceps blade, as described, between the brow and the pelvic brim, if actually accomplished, was a dangerous procedure.

The relaxing effect of chloroform would have been of great service in facilitating version or the operation of converting into vertex or face presentation.

Perforation and the use of the cephalotribe, would seem to have been the proper method of delivery after the death of the fœtus.] J.

Treatment of Vomiting of Pregnancy.

Prof. C. BRAUN, of Vienna, treats vomiting in pregnancy by bathing the vaginal portion of the uterus with a ten per cent. solution of nitrate of silver. We notice in the *Practitioner* for June, in reports for the clinic of the month,

notes of a case reported by Dr. Braun to which he was summoned, the patient being regarded as moribund. The woman was in the first half of her pregnancy and extremely reduced in consequence of intractable vomiting. The physician who had charge of the case had decided to produce premature delivery as a last resort; but Prof. Braun, who is opposed to this practice, decided to apply the nitrate of silver as described. This was done, and the surface quickly dried, to prevent further cauterization. It is said that the success of this treatment was so immediate and so great that an hour afterward the patient enjoyed a meal of roast veal, and there has been no vomiting since.—*Ther. Gazette.*

[The practice of Prof. Braun probably does not differ from that of most obstetric authorities who resort to abortion only as a means of saving life when all other measures have failed. That abortion is the only means of averting death in a certain proportion of cases is undeniable. The nitrate of silver will be found most useful in cases attended with erosion of the cervix.]

J.

Dystocia.

M. DAPPAUL communicates to the French Academy of Medicine the following interesting case of dystocia: The patient was thirty-two years old, in good health, and nearly at the close of gestation. Five days previous to her entrance into the hospital there appeared at the vulva a livid elastic mass, about the size of a man's fist, emitting a horrible odor. The midwife and physician called in, pronounced it a placenta. On examination, it was evident that it was but the prolongation of another tumor, much more voluminous. Labor came on the same day, and soon the exterior tumor

became so large that it was almost impossible to pass the fingers into the vagina. The movements of the foetal heart becoming feeble and irregular, he drew out the tumor, little by little, with his hand, until he had a mass of enormous size in comparison with the cavity which had contained it. It proceeded from the left side of the entering lip of the uterus. He cut the pedicle without serious hemorrhage following, and quickly extracted a living child. The tumor weighed 1,790 grammes, was fibrous and quite vascular.—*Obstet. Gazette.*

Child-birth Complicated by Ovarian Cysts.

Dr. LOUER, of Leipzig: From the histories of all cases of ovarian tumors complicating child-birth, and a few new cases from the *Leipsiger Clinic*, he draws the following conclusions:

In births, complicated by ovarian tumors, therapeutic measures should not be withheld too long.

In all cases reposition of the tumor should be attempted.

If reposition fails, puncturing the tumor should be resorted to.

If the contents are too viscid to flow, a large incision should be made into the cyst wall.

All other operations, as excision of the cyst, should, on account of the danger attending them, be avoided.

In case of solid ovarian tumors, perforation and caesarean section may be used, the choice being according to circumstances and the skill and wishes of the operator.—*Deutsche Med. Zeit.—Ibid.*

Changes of Uterine Muscular Tissue After Parturition.

Prof. WOJTSCHECOFFSKY has examined microscopically ten uteri, removed from women who died within thirty-five

days post-partum. He offers the following as the result of his investigations:

1. The fatty degeneration of the uterine muscular tissue, upon which the diminution in size of the uterus depends, begins immediately after parturition, and covers a period of more than five weeks.

2. The degeneration attacks alike all parts of the organ (fundus, corpus and collum).

3. It could not be ascertained whether the process began at an earlier period in the outer or inner muscular layer of the uterus.

4. The interstitial tissue of the uterus does not take an active part in the process of involution.

5. The process of obliteration of the blood-vessels covers a greater period than the entire involution.

6. The appearance of free pigment in the uterus is not stationary.—*Deutsche Med. Zeit.*

Report of Labor Cases.

In the transactions of the Medical Society of West Virginia, Dr. W. H. Shaw gives his record of five hundred and eight cases of labor, from which we make the following abstract: Of this number three were twins; five hundred cases, presentation by the vertex; eight by the breech; two by face; one, transverse. Average length of labor, eight and four-one-hundredths hours. Post-partum hemorrhage occurred in nine cases.—*Chic. Med. Review.*

Phlegmasia Alba Dolens.

To the St. Louis *Courier of Medicine*, Dr. P. V. Schenck contributes a lengthy article on this subject. After reviewing the various opinions that have at different times been advocated concerning

its etiology, and leaving the matter in as much doubt as ever, he comes down to treatment, in which we find the following practical suggestion: "There is no doubt that bandages aid the absorption of the effusion, and diminish the size of the limb, and the advisability of this treatment is no longer questioned. The only point is when to use it, and how to apply the pressure, and what material to use. The fresh skin of animals was once used, and it was supposed to possess a certain advantage outside of the mere pressure. Next muslin was tried, then flannels, then chamois skins were applied, then silk in the shape of long elastic stockings; but my experience has been so favorable in the use of Martin's rubber bandages that I think it worth while to call the attention of the profession to their application. The use of these bandages has become almost universal; there is no need of describing their mode of application, every surgeon applies them, the general practitioner employs them, and the obstetrician and gynecologist are now trying them, as a utero-abdominal supporter.

Cæsarean Section.

Prof. Spaeth, of Vienna, performed Cæsarean section and sewed up the uterine wound with five deep and four superficial catgut stitches, largest size of Lister's antiseptic chromic acid ligature. The woman died forty-eight hours after of peritonitis. The autopsy was surprising in its revelations. Every catgut suture in the uterine tissue was found untied and straightened out, while the wound was open and gaping, the lochial discharges having escaped into the peritoneal cavity. The original knots in the catgut had been tied with especial care by Prof. Weinlechner.—*Phil. Med. Times.*

DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

DISEASES OF WOMEN.

Eversion of the Cervical Endometrium in the Imparvus Uterus.

Prof. A. J. C. SKENE, M. D., Brooklyn, N. Y. There is a condition of the cervix uteri which is not referred to in our books on gynecology but is none the less worthy of attention. The appearance of the cervix as seen through the speculum resembles very closely an ordinary bilateral laceration, with inversions of the mucous membrane. Something of the same physical signs are obtained by the touch. If the anterior and posterior walls of the cervix are approximated by a pair of crossed tinacula, as recommended by Emmet in the diagnosis of lacerations, two lateral fissures are developed which give the diagnostic signs of double laceration. So closely do the physical signs resemble those of laceration, caused by paturation, that in my first case (a young, unmarried lady) I suspected that she had adopted a social order of things contrary to that prescribed by law.

I soon found that in this I was mistaken. Other cases followed, until I have seen twelve, in five of whom the hymen was found intact, which showed that the condition was not due to any traumatic cause.

Investigating the pathology more fully I found that there was a superabundance of the mucous membrane of the cervical canal, especially of the anterior and posterior walls. In fact, the quantity of the mucous membrane was more than could be contained within the cervix, and hence it became prolapsed, or inverted. In the majority of my cases the arbor vitæ was seen in

that well-defined condition which only exists in the imparvus uterus. In all cases there was marked catarrhal inflammation of the mucous membrane, and at its most dependent portions there was erosion. The deep red hue of the cervical membrane contrasted in a striking degree with the light, pink-color of the membrane of the vaginal surface of the cervix.

The genesis of this condition is still uncertain, so far as I know. At first I supposed that there was a congenital fissure of the cervical walls which permitted eversion of the cervical membrane, but the effect of treatment upset that theory. As soon as the superfluous membrane of the cervix was disposed of, the muscular walls contracted and assumed their uniform outlines, no trace of any fissure remaining.

I then thought it might be a hyperplasia of the cervical mucous membrane produced by a long continued inflammation. This was made very doubtful by the fact that well-defined endocervicitis is frequently seen while this condition is rare.

The most rational view of this matter, and the one I am inclined to adhere to is, that it is a mal-development in which there is an excess of mucous membrane of the cervix in proportion to the muscular walls.

There is, however, another possible malformation which might give rise to the same condition, viz.: an arrest of development of the muscular tissue at the end of the cervix which would leave a funnel-shape in place of the constriction which forms the os externum. This is rather improbable.

The symptoms in these cases were such as are present in endocervicitis generally.

My first cases were treated by the hot water douch and applications of carbolic acid and iodine. Nitrate of silver and sulphate of copper were used in my first case of all. This treatment gave very unsatisfactory results. Some improvement in the inflammation followed the long-continued use of these remedies, but complete recovery was not obtained.

I then tried excision of the superabundant mucous membrane and the results were entirely satisfactory.

The operation consisted in removing a transverse section of the mucous membrane as shown in the accompanying diagrams.

The first represents a longitudinal section of the cervix with the inverted

ter the excision of the membrane, were approximated more perfectly than they could be by any other means.

Fairly good results might be expected without using sutures at all, but leaving the os gaping gives large surfaces to heal by granulation and contraction. The results so far have been satisfactory. The most marked case of this kind that I have ever seen was a young lady of delicate health, who had had uterine symptoms from puberty. When she was admitted to my private institution the extremity of the cervix measured one and one-half inches in diameter, and looked like the granulating stump of a cervix which had been amputated. After being operated upon the cervix was reduced to an inch in diameter, and the mucous membrane of the canal was completely covered in.

There is one condition of the cervix



mucous membrane. The second shows the same with the sections removed, and the third represents a section of the cervix after treatment. The oblique lines in figure three running out from the os externum indicate the points of union. After removing the V shaped sections four sutures were introduced, two on each side, and the parts brought together in the same way as in operating for ordinary lacerations of the cervix.

I found that in drawing together the anterior and posterior lips of the os externum, the edges of the spaces left, af-

which I have seen which resembles in appearance this affection; this was a cervix uteri, part of which had been amputated by hot wire loop. The walls of the cervix had retracted and left the mucous membrane of the canal everted.

Myotomy by the Intra-Peritoneal Method.

Dr. GEORGE FISHER, in Hanover, reports the following case in *Deutsche Zeitschrift für Chirurgie*:

The time seems not to be far distant, when the method of dropping the pedi-

cle back into the abdominal cavity (Stielversenkung) will be generally adopted in myotomies. Indeed, in dealing with myomata with thin pedicles the intra-peritoneal method is recognized everywhere, but as to tumors with a broad base, it is still an open question, whether or not they should be treated by the extra, or intra-peritoneal method. The latter is advocated in Germany by Schroeder and Olshausen, while Kaltenbach, on the other hand, favors the extra-peritoneal treatment of the pedicle. Schroeder, at the meeting of German naturalists at Salzburg in 1881, could report nine cases in succession, in which cuneiform excision of the pedicle and dropping into the peritoneal cavity had been successful. In December, 1881, Olshausen advocated the same method, and warmly upheld the position, that the same principle which had been established for the pedicles of ovarian tumors, must be adopted for all tumors. In addition to the wedge-like excision he recommended, as a second method for tumors with a broad base, ligation of the pedicle *en masse*, amputation by caoutchouc ligature above, and dropping back of the pedicle together with the ligature. To uphold this he could refer to two cases only, but they were successful.

My case is as follows :

In a lady sixty years of age, of delicate constitution, who has been a widow since 1859, and has never had a child, an abdominal tumor was noticed in 1870. During the next eleven years its growth was so slight that it could always be spanned with one hand. Excepting some constipation, the ailments were slight; there was no hemorrhage at all. In the fall of 1881 the tumor increased, occasional peritoneal irritation set in and compelled the patient to remain in bed. These attacks increased in frequency

during the last month; the pain was now violent, so that a few days excepted the patient was continually kept in bed. All other organs were healthy.

There was now in the abdomen a tumor larger than a man's head, extending from the symphysis pubis to the umbilicus, but leaving free both hypochondriac regions. It presented a spherical outline with smooth surface; on the left side only, above the symphysis, a little elevation could be felt. It was of firm consistence, presented no signs of fluctuation, and was easily movable to either side. Percussion over the tumor elicited a dull, over the hypochondria a tympanitic sound, there was no ascites. Pressure on the right side of the tumor, below the umbilicus, caused intense pain. The neck of the uterus was soft and flabby; neither here nor from the roof of the vagina could a tumor be felt. Only when by pressure upon the abdominal walls, the tumor was pushed down, some hardness was felt in the anterior cul-de-sac. A sound could not be introduced into the uterus, since the os uteri was permeable only to the extent of hardly 1 cm.

The diagnosis was subserous myoma of the uterus, based upon the fact that the tumor was firm, easily movable and could not be found by examining through the vagina; that there had never been any hemorrhage. Unfortunately the uterine sound was of no use in the diagnosis.

Operation on April 19, 1882. As danger from shock was to be anticipated in so old a lady, I had, in addition to the usual coverings in ovariectomy (flannel shirt, woolen blankets around the legs), the patient laid on a pillow filled with warm water, and heated bricks applied to both legs. As little of chloroform as possible (30 grm.) was used. After ligating the pedicle the patient awoke,

drank a glass of wine and remained conscious during the rest of the operation. Under spray an incision was made in the linea alba from the umbilicus downwards. On opening the thin abdominal wall a glistening tumor of snowy whiteness appeared. On the right side there were a few adhesions between the peritoneum and tumor, which were easily removed by the finger-nail.

To lay the whole tumor open the incision had to be enlarged, and conducted around the umbilicus on the left, so that its length was now 15 ctm. As it was impossible to extract the tumor in the transverse diameter of the opening, it was turned and lifted out of the abdominal cavity lengthwise. There were no other adhesions. The tumor, on the smooth surface of which several strong vessels were seen, was connected with the atrophied, hardly discoverable uterus, by a membranous pedicle three fingers wide. The ovaries were also atrophied. An assistant held up the tumor, which was wrapped up in a towel, but did not pull. A second colleague held the abdominal walls firmly and completely closed around the tumor, in order to protect the abdominal cavity from spray, and to prevent the entrance into the abdomen of the blood from the pedicle. A firmly stretched, strong caoutchouc-ligature (4 mm. thick) was placed twice around the pedicle. Another assistant, with a pincette, held the ligature at the crossing of its two ends, and the ligature was closed by a triple knot. To secure the ligature in its place a strong silk thread was placed around both ends, and the ligature itself was sewed upon the tumor with silk thread on both sides. The pedicle was divided by a transverse cut, 2.5 ctm. above the ligature; the amount of blood flowing back from the pedicle not being considerable. The pedicle was not

broader than the palm of a small hand, was pale and did not bleed. As it was quite easy to bring the opposite edges of the cut together, I did not make a wedge-like excision, but united the surfaces by six deep-seated sutures of coarse silk at the base of the pedicle, and the edges by eight superficial sutures of fine silk. Not a single drop of blood was lost. The pedicle with the caoutchouc ligature was returned into the abdominal cavity. Dressing of the peritoneum was very light, because no blood had flown into the abdominal cavity. The wound in the abdominal wall was closed by two silver sutures and twenty superficial silk sutures. Lister dressing.

The tumor, weighing three pounds, was a fibro-myoma, in which the non-striated muscular tissue exceeded the fibrous tissue considerably.

There were no symptoms of collapse; recovery without any interruption. On the fifth day the dressing of the wound had to be renewed, because it had been moistened with urine during night, which occurrence had caused so much excitement in the patient, that her temperature rose to 38.40°C. on the next morning. At the same time all the silk sutures were removed. At all other times the temperature ranged between 37.1° and 37.9°. The pulse had always 90 beats. On the twelfth day the silver sutures were removed, the wound had healed per primam. The patient continued well, left her bed on the eighteenth day, and was dismissed on the twenty-eighth day, wearing an elastic abdominal supporter.

This case supports the intra-peritoneal method in removing myomata of the uterus. By Olshausen's two cases it had been proved that a well disinfected caoutchouc ligature can heal up without causing any reaction in the abdominal cavity. His cases were the cause of

some successful experiments on animals with the elastic ligature left in the peritoneal cavity. (Kasprzik, *Berl. Klin Wochenschrift*, No. 12, 1882.)

On that occasion, Hegar recommended, as a means for applying the elastic ligature, a forceps with smooth blades and rounded edges, having a spring catch to fit its jaws. In this case I have not missed such a forceps; an anatomical pincette was sufficient to fix the elastic string at the crossing of its ends, so as to secure the formation of the knot. Even strong pressure with the indented pincette will not injure the thick caoutchouc string.

It is to be mentioned here, that, although the pedicle had been removed without excision, the surfaces were easily brought together and united. In cases, where a caoutchouc ligature is applied permanently, cuneiform excision would favor slipping of the ligature. Olshausen says he will in future cases, by the intra-peritoneal method, not take the trouble of dressing the stump with peritoneum. But when, as in this case, the union of the edges is so easy, it should be done, because the safety of the operation from hemorrhage as well as from sepsis is increased by it. Besides it might be possible that, as long as the decay in the ligated pedicle has not progressed far enough, adhesions between the intestinal walls and the broad open stump might be set up, which in their turn, might cause occlusions of the intestines, as has been reported by Hegar and Kaltenbach (*Operative Gynaekologie* p. 452, 1881.)—*Obstet. Gazette*.

Health of Criminal Women.

Dr. E. M. MOSHER, in an article upon this subject (*Boston Medical and Surgical Journal*), comes to the following conclusions:

First.—Intemperance and unchastity are the two vices which fill our penal institutions with women.

Second.—The influence of these vices is detrimental to health of body, increasing its susceptibility to disease, and lessening its recuperative power.

Third.—The diseases which follow as a direct result of these vices are syphilis, alcoholism, dyspepsia, rheumatism, and general anæmia.

Fourth.—Morbid conditions of body react upon the moral nature, increasing and perpetuating the tendency to criminality; hence the importance of careful medical supervision as a reformatory measure.

Fifth.—More ample provisions should be made in all large cities for the isolation and thorough treatment of venereal patients of *both sexes*, either by the addition of special wards to the general hospitals or by the establishment of hospitals for this class.

Sixth.—The women who commit high crimes, that is, larceny, burglary, arson, manslaughter, etc., possess a more sensitive nervous organization than those who commit only offenses against chastity and public order.—*Med. Record*.

"Vesico-Vaginal Fistula Cured by Position"

Is the title of a case published by Dr. J. T. WINN in the *Virginia Medical Monthly*. The fistula occurred in a woman recently confined. She was told to assume the genu-pectoral position at intervals, thus allowing the urine to accumulate in the fundus of the bladder. No catheter was used. A moderately strong solution of sodium bicarbonate was used as an injection immediately after each urination. In twenty days the cure was complete.

[Such fistulæ will sometimes become closed by the natural reparative powers.

Whether position has everything or anything to do with it remains to be proved.]

A. J. C. S.

Periodical Sore Throat recurring at each Menstrual Epoch.

DR. GENET (*Journal de Médecine et Chirurgie*, October, 1882) describes a sore throat which makes its appearance with great regularity a few days before each menstrual period, and subsides upon the appearance of the catamenial flow. It is characterized by a slight sensation of dryness in the throat, with thirst, and a little tickling cough. There is neither fever, headache, foul breath, nor any actual pain in the throat. Examination shows a slight redness of the fauces, and a little swelling of the tonsils. The affection lasts two or three days and disappears immediately upon the establishment of the menstrual flow. At the menopause, when the courses become irregular, the sore throat ceases to appear every month, but is observed only before the catamenia, at whatever time the flow may occur.—*Med. Record*.

Eye Diseases Dependent upon Suppression of Menses.

In the *American Journal of the Medical Sciences* for October, 1882, Dr. R. J. MCKAY reports twelve cases in which suppression of the menses was accompanied by disturbance of vision. Cases of this kind demand prompt recognition as to their etiology (before vision is too much impaired by the internal eye disease) in order that they may be successfully treated and relieved. Partial loss of vision and inability to use the eyes in young healthy-looking females, without external eye disease, always suggest to his mind the probabilities of menstrual disturbance, and he makes it a rule to at once inquire about the matter.

Young school-girls often manifest

asthenopia (weak and painful sight) about the time their menses are being established, and especially if their menses become irregular from any cause, which may produce partial or complete suppression for an indefinite time. Sometimes they manifest decided congestion of optic papillæ and retinae, and others no internal eye lesion, with exception of strain of their accommodation. This is common to all such cases, for they have some refractive deformity of their eyes. The latter sooner or later causes their muscles of accommodation to rebel from their over-taxing and too continuous work.—*Ibid*.

[It is possible that the conditions of life which cause menstrual derangements produces the defects of sight, and that the two affections have no causative relations to each other.] A. J. C. S.

Sponge Tents.

DR. FRÄNKEL gives in the *Centralblatt für Gynäkologie* his method of using sponge tents, which must commend itself for its safety. He rubs it down with salicylated cotton, rolls it in coarsely-pulverized iodoform, until its surface is thickly coated. After insertion he packs iodoform gauze around the vaginal portion of the uterus. The vagina instruments used, operators' hands, etc., are all to be thoroughly disinfected.—*Obstetric Gazette*.

[The dangers arising from the use of sponge tents are twofold. They act as foreign bodies, and excite traumatic inflammation if left long in position. And, again, they may act as media for the introduction of septic material. The above method will guard against one of these dangers.] A. J. C. S.

Ovarian Pressure.

A Paris correspondent of the *Chicago Medical Journal and Examiner*, speaking of the results of ovarian pressure as practiced by Charcot at the Salpêtrière, says :

"One of the first patients presented was a young girl of charming appearance. The only visible sign of a departure from normal physiology was a persistent inward contraction of right foot. She was, however, wearing a ceinture which produced pressure in the region of the ovaries. The ceinture was removed, and immediately a violent fit of coughing was developed, which, even for the short time that it was exhibited, was positively painful to observe. The ceinture was re-applied, and the coughing ceased as by magic. Another patient was presented, with whom the removal of the ceinture was followed by the regular development of the various stages of epilepsy, exhibiting all the violence of agitation, frothing at the mouth, rapid, powerful muscular movements, followed by the most complete opisthotonos. The application of the ceinture cut short these paroxysms at any particular stage of their development with the most remarkable promptitude. Some half dozen patients were presented, illustrating in a similar way the same influence. In one case, when the removal of the ceinture was not followed immediately by an onset of the epileptic attack, the assistant gave a very slight but rapid tangential blow of the hand in the small of the back, and immediately the epileptic attack began culminating in the cataleptic condition.

"One case was exhibited of unusual interest, on account of its history. Becoming pregnant, it was found that the points on which pressure had to be exerted in order to relieve the attacks of

epilepsy, gradually ascended as the pregnancy developed."—*Boston Medical and Surgical Journal*.

Subinvolution of the Uterus.

Dr. JOHN WILLIAMS delivered an address on this subject before the Section of Obstetric Medicine, at the recent meeting of the British Medical Association (*British Medical Journal*), in which he said that the causes of subinvolution are—general debility, multiparity at an advanced age, post-partum hemorrhage, retention of portions of placenta and membranes, lacerations of the perineum, and pelvic inflammations. Its results are hemorrhage, dysmenorrhœa and prolapsus. Some of these causes, as post-partum hemorrhage, perineal laceration, pelvic inflammation, retention of portions of placenta and membranes, can in a great degree be prevented. Wounds of the perineum should be immediately and completely closed. It is very important to remove the discharges from uterus and vagina, to be effected by abundant hot vaginal injections (three or four pints; temperature 110°-115°) commenced immediately after delivery and repeated twice a day at least. They should contain a disinfectant.—*Med. and Surg. Reporter*.

DISEASES OF CHILDREN.**Turpeth Mineral in Croup.**

Dr. FORDYCE BARKER, of New York, places great reliance on this drug in croup. Dr. E. R. Duval stated at the last meeting of the Medical Society of the State of Arkansas (*Transactions*), that "for twelve years, after the manner of Dr. B., I have been using the turpeth mineral in the treatment of this disease, and I have, since the adoption of this plan, lost no case of croup.

My treatment has been, immediately

upon being called to a case, without stopping to interrogate very closely as to whether I have a croup reflex, catarrhal, or true croup, to administer at once a dose of the agent (from two to five grains, according to age) in honey, syrup, or sugar of milk, and if there is no decided emesis within fifteen minutes, to repeat the dose; and I have never known it to fail to vomit at the second dose; almost immediately a satisfactory response is secured by the first administration. The vomiting is usually free, without effort and without depression. The powder is tasteless, small in bulk, prompt in action, and thorough in effect.

The virtues claimed for it are sedative and revulsive. "It depletes the mucous membrane by an abundant secretion of mucus, which is thrown up; it removes from the larynx, by the forced expiration which it causes, any albuminous or fibrinous exudation which may be there in a diffuent state, and which by remaining may become, subsequently, pseudo-membrane; it acts as a powerful revulsive, and thus diminishes the capillary circulation in the trachea and larynx; and thus it becomes a most effective agent in arresting the inflammatory forces."

If the croup persists after removing the causes of reflex action, then, of course, other therapeutic agencies will need to be essayed; but throughout the attack, be it short or long, whenever the breathing becomes suffocative, from the accumulation of mucus in trachea or larynx, I give the turpeth mineral in the manner and according to the conditions and plan above designated.—*Med. and Surg. Reporter.*

Morbili Scarlatina.

An eight year old boy was affected with mild catarrhal symptoms of the res-

piratory passages and of the conjunctiva, being attacked by measles. On the fourth day, when the temperature had resumed its normal again, it suddenly ascended; there was enlargement of the spleen, angina and scarlatina exanthem, with miliary eruption. On the sixth day, mealy desquamation of the face, neck and throat; but synchronously the scarlatina eruption spread further; stomatitis developed itself, and then desquamation in flakes took place, which outlasted the mealy desquamation. Convalescence set in and the boy got well.

While it is generally thought that two such infectious diseases will not break out in the body at one and the same time, in this case their consequences, at least, seemed to have gone hand in hand with each other.—*Ibid.*

Pathology of Measles.

The celebrated authority on diseases of children, Prof. HENoch, in Berlin, communicates the following instructive case to the *Berlin Klin Wochenschrift*, 1882, No. 13.

In a girl, aged 4, the eruption of measles during the first two days was normal; but on the third day (the fever continuing uninterruptedly), all over the body; large vesicles (from the size of a hazelnut to that of a silver dollar) made their appearance, filled with a yellowish serum. The eruption of measles assumed a dark red, hemorrhagic form. The vesicles could be seen, not only over the measles-exanthem, but also on parts of the skin otherwise perfectly healthy. After cessation of the vesicular eruption, on the fifth day, the fever abated, but between the sixth and seventh days the temperature ascended again to over 40° C., and a fibrinous pneumonia in the right lower lobe developed itself, which

on the eighth day caused the death of the child. A post-mortem examination was not permitted.

Henoch considers the case to have been one of morbilli complicated by pemphigus acutus, and not, as Stemmer (*Cbl.* 1874, p. 575) contended, in a similar case of his own, as the product of a dermatitis morbillosa developed to the highest degree.

We only wish to remark, that the vesicles should have been examined for bacilli. Not long ago we reported in this journal several cases of diabetic persons, where the sudden breaking out of abscesses was found to have been caused by bacteria. We do not doubt that, from some cause or other, micro-organisms of a special type found their entrance into the circulation and gave origin to the pemphigus eruption. We have further, here, again the proof that two diseases may co-exist with each other.—*Ibid.*

Caput Obstipum.

The *Obstetric Gazette* says that Prof. ALBERT, of Vienna, recently exhibited a child with this affection. The head is inclined to the left; that is, the lateral plane is abnormally near the left shoulder. This condition is usually congenital, and is due generally to peculiarities of the position of the fœtus in utero, allowing contraction of the sterno-cleido-mastoid muscle. In breech presentations and difficult forceps delivery, a laceration of this muscle may occur, with, consecutive inflammation and contraction. A mere restitution of the head is of no use; the shortening of the muscles must be counteracted by subcutaneous division, followed by orthopedic treatment.

During the first four or five days the patient must lie upon a hard bed, with the head in a horizontal position. When the soreness has passed away put on the

Dieffenbach cravat, which is so firm and high on the affected side as to prevent a return to the faulty position. Acquired caput obstipum may be spastic or paralytic, or the result of cicatricial tissue building, or originate in changes in the spinal column.—*Ibid.*

Pleurisy in Children.

The following is a portion of a clinical lecture by Dr. WM. T. PLANT, published in *Obstetric Gazette*:

In the young as in the mature, pleuritis is almost always unilateral, and that is a blessing, for thereby we are furnished with a standard of comparison.

It is practically important that you should know that it occurs under different conditions. It may be *primary*—standing apart from any other disease; or it may be *secondary*—that is, attendant on and sequent to some other malady as pneumonitis, scarlet fever, nephritis, rheumatism or pulmonary consumption.

As a primary affection, its usual cause is taking cold. It may happen to the youngest infant, though it is mostly met with in children who are older and more liable to exposure. In grown people the initial symptom is a chill. Not so in infancy and not generally so in childhood. Sometimes vomiting is the first thing noticed; sometimes a convulsion or a series of them. But usually the first symptom of prominence is pain—a stitchy, stinging pain. Though infants cannot tell you this, the fact of pain is often made evident by fits of crying and screaming and a disinclination to be moved from a chosen position. Older children will indicate the seat of pain. In most cases, perhaps, it is in one side near the nipple; but quite often it is not in the thorax at all, but in the upper part of the abdomen, and the child's constant wail may be that his "belly hurts." I would have you make a

mental note of this, for not a few children have been treated for colic when the real trouble was pleuritic. I suppose the reason of this is to be found in the fact that the lower intercostal nerves are distributed to the integument of the abdomen. The pain of pleuritis in early life varies greatly as to intensity. Sometimes the little one appears to be in the extremest distress, and there may be such tenderness of the affected part that the least pressure causes flinching. In other cases the pain is moderate and not lasting. Though I cannot give you the reason, I may mention the fact that the pain may remain limited to one small spot, though all the pleura of that side may have become inflamed.

I may as well tell you here that you will sometimes fall in with cases of pleurisy that are latent as to pain and other prominent symptoms. A child that had not been known to be seriously ill is brought to you for an opinion as to the cause of its failing health. You examine it and find one side of the thorax full of fluid. Insidious pleurisy is rather frequent in early life, especially in connection with scarlet fever and some other diseases.

The next symptom that will in most cases engage your notice is the cough. A child in the first days of pleuritis handles its cough with the greatest caution. It is short, dry, and frequent, and the pain that it causes and the efforts to suppress it are often depicted in the features. But the cough is as variable as the pain. In some cases it is well nigh constant; in a few so slight as scarcely to attract notice. But please to notice that the cough *follows* the pain—the latter generally having a lead of half a day or more.

Another point is the fever. Pleuritis, like other affections ending in *itis*, is attended by a rise of temperature. I think

it is seldom quite as high as in acute pneumonia. The difference in surface heat between these two divisions may be strikingly evident to the hand. In pneumonitis the integument is often "burning hot;" in pleurisy it feels but little warmer than nature. In pneumonitis also the face is flushed, often crimson; in pleuritis, if there is a little flushing at first, it soon subsides and leaves the countenance pale and often rather sallow. Notice also the decline of temperature in the two diseases. In acute pneumonia it is sudden; at the end of a week or thereabouts the crisis occurs and the temperature falls quickly—in one day—to the normal or even below it. But in pleuritis the decline is always gradual. Often two or three or more weeks pass before it drops to the standard of health. The pulse is, of course, quickened in its pace, and there are the usual attendants of the febrile state.

Occasionally, in the first days, when the fever is at its highest, there is severe headache and active delirium; and if there is also vomiting and constipation you may lean towards a diagnosis of cerebral inflammation. But consider and weigh all the symptoms and carefully examine the chest and you will seldom go wrong.

Another feature of this disease that claims your attention is the breathing. It is hurried, but less so, as a rule, than in pneumonia. If you observe it carefully you will be struck with its superficial character. The child prefers to breathe frequently rather than deeply, for it has learned that a full breath excites the cough and causes pain. There is seldom either much dyspnea or lividity. If the child needs more air, it breathes oftener rather than deeper. Sometimes there is a little expansion of the nares and an expiratory moan, but these fea-

tures are seldom as prominent as in pneumonitis.

Altogether the child will probably seem to be less ill than are children with acute inflammation of the substance of the lung, nor is there at the end of a few days that sharp turn for the better that characterizes the latter disease. The natural result of an inflammation of the pleura is, as you well know, an increase in its functional activity; hence an exudation of fibrinous lymph or of serum, or both. Layers of fibrin are deposited on the pleural surfaces while detached shreds and floculi of it float in the fluid that is accumulating within the cavity. In most instances this fluid is a clear serum; but here is a point that I would emphasize: In children this fluid has a remarkable tendency to become purulent; sometimes, indeed, it has this character from the very first. This is empyema.

The amount of effusion is variable. There may be but two or three ounces—not enough to hamper the lung in its movements; or there may be sufficient to fill the cavity full and over-full, so that the lung, retiring before it, is crowded into a corner at the upper and inner part of the chest—an airless, bloodless, leathery lump.

I hardly need to tell you that, as a result of excessive effusion, the diaphragm may be pressed downward, the heart crowded to one side, the intercostal spaces rounded outwards, and the side considerably increased in its measurement. The increase in size, however, may be difficult to estimate, because the other side may be enlarged as much from the increased volume of the sound lung that now has double work to do.

I have gone somewhat minutely into the general symptoms because the physical signs on which in the pleuricities of adults we can plant ourselves with so

much assurance are often, in children, unreliable and misleading. Especially is this so at first. Auscultation is unsatisfactory, because the child breathes as superficially as possible, and the friction sound is seldom caught in infants and young children.

After some days, when considerable effusion has occurred, a diagnosis is not difficult. The flat, toneless thud, and the sense of great resistance on percussion, are of themselves almost conclusive of a fluid accumulation. Above the level of the liquid the sound will be clear and tympanitic. In some instances the diagnosis may be happily confirmed by observing that the upper line of dullness varies with changes in the posture of the child. But often the fluid is confined by fibrinous partitions, or the pleural sac is full, and then this test is not available.

In the adult, when the effusion is large, all respiratory sounds may be absent, and the results of auscultation are only negative; but in children there is seldom so much fluid between the lung and the chest-wall as to do away with bronchial breathing, and quite often the vesicular murmur may still be faintly heard. This will not be so, of course, when the accumulation is so great and the pressure so long continued as to wholly close the lung to the entrance of air. But in any event the contrast between the diminished air sounds of the crippled side and the exaggerated respiration and hyper-resonance of the sound side will be so pronounced that there should be no error of diagnosis. When there is much effusion it may be both seen and felt that the usual mobility of that side is lessened.

Some writers speak of a change of shape as a sign of large effusion, consisting in lateral flattening and anterior bulging.

You will not forget that in the young, pleurisy and pneumonia are often concurrent—pleuro-pneumonia. In that case you will recognize the prominent symptoms of both diseases, and you will give a guarded prognosis, for the condition is one of extreme peril.

In early, as in mature life, pleurisy may terminate in different ways. In many—in most cases, the fever ceases within a few days; the exudation is speedily absorbed; the lung regains its former volume, and within two or three or four weeks the child may be as well as ever. In some cases, and especially if the pleurisy is secondary to other disorders, the child may die at length from diseases and exhaustion. In many instances, the fluid, if not purulent at first, soon becomes so. I think I have already stated that suppurative pleurisy is much more frequent in the young than in older people. Secondary pleuritis is very often of this character. Empyema is always a serious disease. It is true that when the quantity of pus is small it may be disposed of through fatty degeneration and absorption, but not so, I think, if the cavity is full or nearly full of pus. It is retained; and before long there are symptoms of pyemic infection, such as high fever, exhausting night sweats and rapid wasting. After some weeks, or months, if the child lives so long, unless your art has provided an outlet for the pus, nature attempts its evacuation either through a spontaneous opening in the chest wall, or internally through the air tubes or esophagus, or possibly downwards through the diaphragm. In children, evacuation through the outer wall seems to be nature's favorite method.

But even when the drain has been established the child does not always recover. The production of pus may keep pace with its discharge until the

patient sinks from exhaustion or falls into a hasty consumption. If it lives and the discharge at length ceases there is apt to be retraction of the side and spinal curvature resulting from atmospheric pressure. In children, however, much oftener than in adults, the crippled lung may by slow degrees become re-inflated and reach at length its former volume, and in this way a very considerable deformity may in time be overcome.

Treatment. "Prompt and very efficient blood-letting is indispensable in the treatment of this form of pectoral inflammation. Blood should be freely drawn with the lancet until a decided impression is made on the pulse. The early application of leeches to the chest is also a highly important measure. As soon as the momentum of the circulation has been moderated a blister ought to be laid over the breast. The bowels must in the first place be freely evacuated by an efficient dose of calomel and rhubarb and kept in a loose state throughout the course of the disease by small doses of calomel and ipecac, or suitable portions of epsom salts."

I have quoted these lines from a great authority in his day, partly that you may see how tenderly the little ones of thirty or forty years ago were treated, but chiefly to caution you against such counsel. Do nothing of the kind. Do just the other way. Avoid reducing measures and seek to preserve the child's strength.

The truth is that most cases of primary pleurisy tend to speedy recovery without medical treatment. Yet we are not on that account to withhold our ministrations.

If the pain is severe, considerable relief may usually be obtained by hot poultices—linseed as good as any—so covered as to retain their heat. More

rapid and complete relief may be had by the hypodermic use of morphine—one-thirtieth of a grain for a child of one year. When the pain is referred to the abdomen a broad bandage so applied as to restrain abdominal and diaphragmatic movement may give some relief.

To quiet the cough at night and secure rest Dover's or Tully's powder may be given in doses of from one to three grains according to the age. At first, while the fever lasts, the diet should be light and simple; later it should be nutritive but plain. Constipation is to be obviated; beyond that I do not believe cathartics are of service.

Some cases require more decided treatment. In weakly children, especially if the pleurisy is secondary, absorption may be for a long time at a stand still. Your first duty in such cases is to determine whether the fluid is serous or purulent. This is easily done by passing the hypodermic needle through an intercostal space in the lower half of the chest. The back is preferable because the child is less terrified when not a witness of the procedure. If clear serum is withdrawn you are justified in resorting to medical means to hasten its absorption. Among these means diuretics have always been in favor. If unable to devise a better, you may use a formula something like this: \mathcal{R} Potassii iodidi, \mathfrak{z} ii; Potassæ nitratis, \mathfrak{z} i; Infusi digitalis, \mathfrak{z} ii; Syrupi simplicis, \mathfrak{z} iss.; Elix., simplicis, \mathfrak{z} i; Misce Aquæ ad, \mathfrak{z} iv.

Signa. Teaspoonful once in four hours for a child three or four years old.

Tonics do well for these cases, and about the best of them is the old muriated tincture of iron. From five to ten drops with syrup and water will not be

too much for a child from one to three years old.

We likewise have local treatment for promoting absorption. Inunctions with blue ointment have, I am glad to say, fallen into merited desuetude. The compound iodine ointment is a good remedy. It may be applied over the effusion with suitable friction from one to three times daily. Eustace Smith prefers the liniment of iodine to any other form. He paints a spot the size of the palm of the hand twice daily until the skin becomes irritated and then works a new field. I believe that small blisters removed from place to place—flying blisters as they are called, are about as efficient agents as we have for exciting the absorbents. Only blisters, even small ones, are irritating and tantalizing to the young, and I seldom use them if I can serve my ends by other means. Seek in all ways to put your patient in good general condition. "Proper nutrition and good air," says Vogel, "are the main essentials to rapid absorption."

Some late authors recommend a "dry diet" to starve out the effusion. I doubt whether much is to be gained in this way, for the system will not long remain in good condition if deprived of a proper supply of fluid.

By perseverance in the use of the above means, with now and then, if the little one is not weak, a sharp cathartic or a sweat, most serous pleuritic effusions will, after a time, become wholly absorbed.

But if the quantity is excessive, if the mediastinum is crowded to one side and dyspnea occur, the fluid should be promptly let out. This may be done by a small trocar and canula, or better, perhaps, by the aspirator. It has often been noticed that the removal of a part of the fluid serves as a stimulus to ab-

sorption, so that the residue is taken care of without further instrumental aid.

Doubtless, mine and your esteemed friend, Prof. Alfred Mercer, of the Chair of Surgery, will give you specific instructions as to the details of chest-tapping, or, to speak less burglariously, *paracentesis thoracis*.

If, instead of abating at the usual time, the fever continues or increases; if there are profuse night sweats and a growing debility and if percussion shows that the fluid is not lessening, it probably is, or is becoming, purulent. If this suspicion is confirmed by an explorative puncture, the sooner you tap the better. It is true that nature may establish a drain and make a tardy and (too often) an incomplete cure, for the proportion of empyemas in children successfully treated by aspiration is much greater than by adults. If the pus re-accumulates after its withdrawal the operation may be again and again repeated.

It seems, sometimes, as if the whole pleura had become converted into a pus forming membrane, so rapidly is it produced. For these cases I think the better way is to make a counter opening; to wash out the cavity daily with warm water *slightly* carbolized or iodinated and to insert a drainage tube. In all cases of empyema, bear in mind the danger of phthisis. Feed your little patient liberally with milk punch, eggs, meat broth and the best food he can digest, and resort early to such agents as cod-liver oil and quinia.

Treatment of Infantile Diarrhœa by Powdered Charcoal.

Dr. GUÉRIN, in referring to a recent communication to the *Académie de Médecine*, made by Bouchardat, remarks that for a long time he has been in the

habit of combating infantile diarrhœa by mixing the milk in the suckling-bottle with charcoal powder. He usually adds half a teaspoonful of the powder to one bottle of the milk. The infants take the milk readily, and in a few days the greenish stools of the little patients change to a dark yellow, while their consistence becomes increased. In addition to the admixture of powdered charcoal, the milk is diluted by one-half or one-third of its bulk of sugared water. He has frequently seen intractable summer complaints yield in a few days to this treatment.

OBSTETRICS.

Treatment of Galactorrhœa and Incipient Mastitis by Strapping.

Dr. E. SCHWARZ (*Centralblatt für Gynäkologie*), reports the cure by strapping of a case of galactorrhœa which had resisted all the commoner modes of treatment. The patient had originally suffered from a suppurative mastitis. The abscess had been opened and iodoform applied. The abscess proper healed readily, but the incisions failed to do so. They, as well as the nipple, discharged milk in considerable quantity. The volume of the breast was increased, and there was moderate tenderness. Anæmia supervened, and the health of the patient was depreciated to an alarming extent. The author finally hit upon the expedient of lessening the blood supply to the affected breast by strapping. By this means he hoped to diminish the hypersecretion. After washing and drying the breast, strapping was applied as follows: Two strips were applied to the tip of the mamma, above and below the nipple, in such a manner as to leave the latter, and a small horizontal ellipse around it, uncovered. The strips thus

formed an elliptical figure. Their extremities ended on the sides of the mamma, that of the lower one above, and *vice versa*. A second ellipse was then applied, overlapping the first to one-half its width. Six or seven of these were applied, of which the last embraced the base of the breast, its ends terminating on the skin of the thorax. Finally, the nipple itself, with the surrounding small space, was covered. Every point of the mamma, above and below, was thus covered by a double layer of strapping, and at the crossings on the sides by more than two layers. Almost immediately after the application, the breast had diminished in size from the tightness of the strapping. There was no pain during the time occupied in putting on the plaster, or thereafter. By the next day only a few drops of milk had appeared through the strapping. The mamma had become so diminished in size that a new application became necessary, followed by a third two days later. Three more applications sufficed to bring about the cure of the dermatitis, arrest the hypersecretion and close the fistulæ. The affected breast now was less in volume than the other. Other procedures had been abandoned on application of the first strapping. In a case of incipient mastitis mentioned, the author, after resorting to others without success, employed the above procedures; but in addition suspending the breasts by two long strips passing over the shoulder. The operation caused no additional pain, but, on the contrary, pain entirely ceased after the lapse of half an hour. A cure resulted after the two additional applications at intervals of two days. In a third case a threatening abscess was aborted. Schwarz draws attention to these points: That the strapping must be carefully applied as described; that the plaster must adhere well; that a

constant equable pressure must be exerted, and that the strapping must be renewed when it becomes loose, this generally occurring daily at first.—*Med. Record*.

The Use of Nitrous Oxide Gas in Labor.

Dr. KLIKOWITSCH (*Meditz Obozrenie*, xv., p. 759) has used this gas instead of chloroform in twenty cases of labor. He considers it much superior to chloroform or ether. Four to five inhalations are sufficient to abolish sensation without affecting consciousness, and its use is free from the objectionable after-effects peculiar to the above named anesthetics. It is said that the inhalation can be carried out under the direction of an intelligent nurse, so that the interposition of the physician is not absolutely necessary.—*Ibid*.

[The chief obstacle to the use of the gas in labor is its cost and difficult portability.]

Case of Interstitial Foetation.

There will be found in the *British Medical Journal* a peculiar case of the above, recorded by Dr. ROBERTS. The patient complained only of stomachache and a continued desire to micturate. About eight hours after the attack, she suddenly died in a state of collapse. The post-mortem showed about six pounds of clot and five pints of a bloody fluid in the abdomen. In this mass there was found a two months' foetus enveloped in its membrane, and with the placenta attached. At the upper part of the uterus there was a rupture close by the right fallopian tube, large enough to contain three fingers. There was no communication between the cavity of the uterus and the sac as formed by the external uterine wall and the fallopian tube.—*Chic. Med. Review*.

Placenta Prævia.

Dr. JOHN REID reports a case of placenta prævia, in the *British Medical Journal*, which terminated rather differently from what is generally supposed to be the rule. Having intentionally lacerated the placenta to some extent, with the result of but covering his fingers with blood, he ruptured the membranes, when only some blood-streaked liquor amnii escaped. Within three hours the labor terminated naturally. The placenta was soon expelled, but the uterus still felt like a large doughy mass; but soon after the expulsion of about a pint of blood, firm contraction of the uterus resulted, and the case progressed favorably. This is one of the many cases which militate against Simpson's theory of hemorrhage in placenta prævia, and may also add some additional force to the objections against meddling with some midwifery.—*Med. and Surg. Reporter*.

Veratrum Viride in Puerperal Eclampsia.

Dr. N. L. GUICE read a paper on this subject at the last meeting of the Mississippi State Medical Association. After reciting several illustrative cases, the author offers the following conclusions.

1. Given hypodermically, in such quantities as will reduce the pulse as low as 60 to 80 beats per minute, the effect upon the spinal nervous centre is such that the convulsive paroxysms are arrested.

2. So long as this effect is maintained by the judicious use of the remedy, the convulsions will be held in abeyance.

3. The convulsions being thus completely within the grasp of the practitioner, time is given, in cases where the

labor is progressing, for its safe completion by the natural forces.

4. Where eclampsia has supervened upon gestation, at any period prior to its completion, or at the end of the same, but prior to the inception of labor, the use of the veratrum viride will, by suspending the convulsions, give abundant time for the induction of labor by gentle and safe means, and for its completion by the powers of nature, thus doing away with the necessity for speedy and forcible delivery and the dangers attending that process.

5. Veratrum is easily and safely administered; it does not produce stupor or otherwise interfere with the intelligence of the patient, and thus enables the attendant to form a better idea of the actual state and progress of the disease.

6. It is believed that if the profession will fairly test the powers of veratrum in puerperal eclampsia, it will be found to possess marked advantages over all other remedies now in use for that disease.

7. The well-known action of veratrum viride as a powerful spinal depressant coupled with its admirable efficacy in controlling the spasms of puerperal eclampsia, should lead to a rigid test of its powers against that painful and fatal disease—*tetanus*.—*Ibid*.

Fissured Nipples.

MONTI recommends that the nipples should be anointed with a (freshly-made) solution of gutta-percha in chloroform, just enough of the latter being added to make the solution fluid. As it dries it forms a protecting pellicle, which does not come off even after suckling.—*Le Practicien*.

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